

ADULT CLIENT OUTCOMES: DIFFERENCES BETWEEN COUNSELORS WITH
EDUCATION IN CHILD-CENTERED PLAY THERAPY VERSUS COUNSELORS
WITHOUT EDUCATION IN CHILD-CENTERED PLAY THERAPY

Brian Christopher Rees, M.Ed.

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APPROVED:

Carolyn Kern, Major Professor

Dee Ray, Committee Member

Dennis Engels, Committee Member

Ron Newsom, Program Coordinator for Higher
Education

Jan Holden, Interim Chair of the Department of
Counseling, Development, and Higher
Education

M. Jean Keller, Dean of the College of Education

Sandra L. Terrell, Dean of the Robert B. Toulouse
School of Graduate Studies

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Child-centered play therapists are taught unique relationship building approaches and therapeutic methods to utilize when working with children. The purpose of this study was to determine if adult clients counseled by child-centered play therapists would demonstrate greater positive therapeutic outcomes than adult clients who were counseled by non-educated child-centered play therapists. This study also attempted to determine if the play therapists' clients would show greater, significant improvement in any particular areas of client distress (i.e., depression/anxiety, relationship issues), more so than the clients of the non-play therapists. Archival data from an assessment, The Adult Self-Report Inventory (ASR), was gathered to measure reported pre and post-test client symptomology. This study utilized a 2X2 repeated measure ANOVA design to analyze the impact of counselors who were educated in child-centered play therapy who saw adult clients, versus their non-play therapy counterparts who saw adult clients. Before treatment pre-test and after treatment post-test administration was collected for use in the analysis.

The population consisted of 60 adult clients seeking counseling services at a major university in the southwest. All clients were seen by Master's practicum students for ten sessions. The clients were divided into two groups – 30 were seen by play therapists, 30 were seen by non-play therapists. Five scales on the ASR were measured using a 2x2 split-plot design and Eta squared. There were three independent variables: group, measurement occasion, and the interaction between group and measurement. The results of this study did not reveal any

statistical significance. However, clinical significance was demonstrated as the play therapists' clients did report greater reductions in symptomology on all five scales, some more than others.

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CHAPTER 1

INTRODUCTION

The value of play as a formidable force in working with children has been strengthened in recent years (Scott, 1998). Play therapy is defined as a form of psychotherapy with children in which play is used to facilitate communication between client or patient and therapist. Play therapy is now regarded as a viable psychotherapy intervention, and researchers have found a large positive effect on treatment outcomes with children (Coleman, 2001).

Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis of 94 different research studies that looked at effectiveness of play therapy. Findings showed play therapy was effective across many different categories including age, setting, and gender, regardless of the counselor's orientation. Play therapy has been a successful treatment modality in dealing with children's fears, phobias, selective mutism, encopresis, trauma, and Attention Deficit Disorder (Kaduson & Schaefer, 2000).

Youngsters' play is their natural medium of communication and expression (Landreth, 2002). Establishing a relationship, understanding, and communicating with children via play are essential elements to successful treatment. Based on the belief that words and verbal expressions are abstractions, and young children are not developed enough to be able to communicate effectively in the adult abstract world, play is children's symbolic language of self-expression and self-exploration. Children can more effectively show through toys and play how they feel about themselves, others, and significant events in their lives (Ginott, 1982). Play therapy is to children what verbally-based counseling or psychotherapy is to adults. Play bridges the gap between concrete

experience and abstract thought. It is the symbolic function of play that is so important to understanding children and promoting their well-being (Piaget, 1962).

A fundamental, primary aspect of play therapy is typically the high level of enjoyment achieved by most individuals. An overall sense of well-being, stress release, and numerous positive affective states result from play. When individuals feel good, their cognitive functioning tends to expand and they feel more energized (Aborn, 1993).

Play therapy can heavily impact emotional expression and mitigate negative emotions. Kennedy-Moore and Watson (2001) stated that expressing upsetting emotions in the play process helps to minimize intensity and helps one to think more clearly, resulting in healthier choices.

A crucial, if not most important, piece of the play therapy process consists of the relationship established between counselor and child. Chethik (2001) found that, as treatment unfolds, an alliance forms, linking counselor and child. Through considerable empathy and understanding, the educated counselor is especially attuned to the child's internal life, seeing the world through the youngster's eyes. The strength of the relationship between the two is not to be minimized. The counselor is taught to become a dependable and enduring individual in which the child relies. The counselor creates a safe atmosphere that allows the child to express one's self fully and genuinely.

During treatment, the counselor/client relationship grows, and therapy becomes more effective. As the child experiences the non-evaluative, freeing environment created by the genuine, caring, and prizing counselor, the therapeutic relationship develops (Landreth, 2002). The play therapist learns how to read the child's body language and how to interpret the child's play, determining what the young client is feeling and

experiencing in life. A child will not completely verbally express feelings, thoughts, and behaviors to the counselor; the youngster does not have the ability. It is the counselor's role to utilize one's education and play therapy experience to glean information and respond therapeutically to the child, helping the client feel understood and work through the pressing presenting issues.

The adult counseling world is much different. Most adults have the ability to express themselves verbally, informing the counselor what they are thinking, feeling, doing, and experiencing. Unlike children, adult clients have the cognitive capability to be completely honest with themselves and maintain complex agendas. They can confront self-deceptions, ambivalence, and motives behind their actions (Kottler, 2004).

The dominant medium used in counseling adults is talk therapy, where the counselor sits across from clients who share information verbally. Counselors typically, regardless of their theoretical orientations, attempt to form close therapeutic relationships.

Kottler (2004) stated the adult client/counselor therapeutic relationship is not unlike the relationship play therapists build in the playroom with children, formed by the counselor listening, watching, and responding to what information child clients are supplying. Similar to the play therapy approach, the adult counselor detects and responds to critical information. Information can be conveyed through transactions other than verbal dialogue from clients; it can consist of body language, non-verbals, or facial expressions. Yet, the bulk of the adult therapeutic process relies on what clients are actually verbalizing to the counselor, and the counselor responds to clients in an adult fashion. There is no interpretation of play and no limit setting. Adult clients talk about their most intimate secrets, powerful insights, and most meaningful feelings. An adequate

counselor will respond verbally to the client, helping the individual explore, reflect, analyze, gain understanding, interpret, and change. On the other hand, the educated play therapist attempts to build a therapeutic relationship of unprecedented magnitude -- full of empathy, acceptance, understanding and encouraging, allowing the child to create, explore, make decisions, and develop self-responsibility (Chethik, 2001).

Whether a counselor is treating a child or an adult, the counselor applies knowledge on the basis of a particular psychological theory in a systematic manner to achieve certain immediate and/or hopefully long-lasting results. The counselor will assess the nature of client issues and implement a prescribed, professional approach of specific interventions, derived from one or another theoretical framework (Zimmerman, 2003).

Landreth (2002) stated that children and adults communicate and express themselves differently; therefore, counselors who treat youngsters effectively should be specifically prepared and educated. According to Pehrsson (1991), counseling with children is different than counseling with adults. Theories and techniques originally developed for adults typically do not work with children, primarily because of different developmentally-related capabilities at the two ages.

The counselor who treats young people develops unique and special therapeutic skills. They include understanding the clients' world and helping children effectively assume responsibility, exploring their feelings, overcoming their issues, and developing feelings of control (Landreth, 2002).

Children experience and see things quite differently than adults. Knowledgeable play therapists work to improve children's self-concepts, reduce various behavior problems, improve emotional adjustment, and increase appropriate play behavior

(Landreth, 2002). This process is accomplished by establishing a powerful bonding relationship, listening, encouraging, limit setting, and the therapeutic utilizing of toys. Philosophers such as Plato and Sartre believed people are most human, creative, whole, and free when they play. Schaefer (2003) also stated play is included in the primary pillars of mental health, interwoven with love and work, enriching humans, and contributing to psychological and physical health.

Statement of the Problem

Many scientific investigations have been conducted on the effectiveness of play therapy. Scientific investigations have also been performed examining the effectiveness of adult psychotherapy (Lambert & Cattini-Thompson, 1996). What appears to be lacking are studies investigating play therapists' clinical effectiveness when working with adult clients. Schaefer (2003) explained how to incorporate play therapy methods when working with adults, and some authors in the fields of psychotherapy and counseling have occasionally discussed various play therapy concepts and procedures to apply with adults. Yet, there appears to be no clear research determining if counselors who have been educated in both play therapy and adult therapy are more clinically effective when serving adults than their counselor counterparts who are not versed in play therapy.

In a landmark text, *The Heart and Soul of Change*, Asay and Lambert (1999) stated that the most important element in achieving successful treatment in counseling is the relationship established between therapist and client. Regardless of a counselor's theoretical approach, clinical effectiveness, counseling skills, experience, or personal style in which one serves clients, the therapeutic relationship built between counselor and client is paramount. The relationship formed between play therapist and child client is

very special and unique (Axline, 1969). Originally formulated in 1947, Axline's eight basic principles of non-directive play therapy serve as a child-centered play therapy guide and beacon for therapeutic contact and relationship building with children:

1. "The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible" (Axline, 1947; p. 73).

Research indicates most play therapists believe forming a constructive relationship is critical to the play therapy process. A considerable degree of communication between child and counselor is non-verbal. Warm smiles, unconditional positive regard, purposeful attention to one's play, and acknowledgement of the child's feelings all aid in nurturing the therapeutic relationship (Carroll, 1995).

2. "The therapist accepts the child exactly as he is" (Axline, 1947; p. 73).

Research indicates many troubled children see themselves as inferior or inadequate. Self-doubt is usually exacerbated by perceived criticism or punishment. Unconditional acceptance given by the counselor helps the child to understand self. Wayward children eventually begin to internalize worth the counselor feels for them without consciously or deliberately realizing it. They eventually come to prize and value themselves (Moustakas, 1959).

3. "The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely" (Axline, 1947; p. 73).

Permissiveness does not imply a total lack of limits, but, rather, implies composure of an atmosphere in which the child's most personal thoughts, feelings, and fantasies are tolerable. A primary task of the play therapist is to follow the child where

the fantasy leads and to attempt to understand feelings the child expresses (Carroll, 1995).

4. "The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior (Axline, 1947; p. 73).

It is unusual for a child to display feelings directly; they usually reveal their feelings symbolically in play. The effective child-centered play therapist helps each child make sense of feelings and use the new found understanding to assist in self-understanding (Landreth, 2002).

5. "The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's" (Axline, 1947; p. 73).

This tenet is crucial to the non-directive play therapy approach. Moustakas (1959) believed a child possesses the ability to work out difficulties, and the counselor must have strong faith in the client's abilities.

6. "The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows"(Axline, 1947; p. 73).

The play therapist offers the child freedom to choose activities to one's liking. One of the many important roles of the play therapist is to attempt to comprehend the significance of the child's choices and to explore ways to share this understanding with the client. The counselor does not attempt to move or direct the child in any way (Carroll, 1995).

7. " The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist" (Axline, 1947; p. 73 and 74).

Children are constantly being hurried along or rushed and expected to adhere to adults' schedules. The majority of children's lives are controlled. The playroom session does not follow this approach. A child's time in the playroom, with the exception of session onset and conclusion, is at the child's own pace and time (Carroll, 1995).

8. "The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship" (Axline, 1947; p. 74).

Novice play therapists traditionally struggle with setting appropriate limits in the playroom. An important task is to keep all participants in the playroom safe; this principle includes both counselor and child. It is also important to prevent damage to the toys and materials. Child clients need to understand that destructive impulses will be acknowledged, contained, and appropriately addressed. It is not therapeutic to hurt one's self or others or to damage toys and other materials. A child needs containment offered by consistent and predictable boundaries (Ginott, 1982).

This non-directive, child-centered approach to counseling and the therapeutic relationship is based on Carl Rogers' Client-Centered Therapy (1951). Most psychological theories and current counseling approaches utilize and accept Rogers' therapeutic principles (Lambert & Cattini-Thompson, 1996). Similarly, Axline's philosophy of unqualified acceptance, empathy, genuineness, and trust are essential to all forms of play therapy, whether child-centered or structured.

Landreth asserted (2002):

Respect for the person of the child and a prizing of the child's worth are not activities of the mind. They are genuinely felt and experienced by the inner person of the therapist and are sensed and felt by the child, who deeply appreciates and values the therapist for such unconditional acceptance. This relationship with the child in the playroom, then, is a mutually shared relationship of acceptance and appreciation in which each person is regarded as an individual. (p.80)

Purpose of the Study

As stated earlier, child-centered play therapists are taught unique relationship building approaches and therapeutic methods to utilize when working with children. The purpose of this study is to determine if adult clients counseled by child-centered play therapists will demonstrate greater positive therapeutic outcomes than adult clients who are counseled by non-educated child-centered play therapists. I will also attempt to determine if the play therapists' clients will show, significantly greater improvement in any particular areas of client distress, such as depression/anxiety and relationship issues, compared to the clients of the non-play therapists.

Review of Related Literature

Counselor/Adult Therapeutic Relationship

As stated earlier, the most important and influential factor in client change that a counselor can influence directly is the degree of the therapeutic relationship established. Without an established high degree of intimacy and trust, little can be accomplished. The sense of safety a counselor fosters is the single organizing principle of the relationship, regardless of the age of the client. Mutual respect, openness, acceptance, and honesty are

critical relationship aspects that help a client explore self and accept valuable feedback, immediacy, and suggestions from the counselor (Kottler, 2004).

Josselson (1992) stated that although many similarities exist between adult personal relationships and adult therapeutic relationships, there are important and fundamental differences. First of all, in a therapeutic setting, the client is obviously in need of help, and the counselor is identified as the specialized individual who will provide professional assistance. Rules of the relationship must be in place for this unique dynamic between two people to function. The client must be on time, willing to be as open as possible, have an understanding of providing the material to be discussed and explored, and understand the nature of the relationship is solely professional. The counselor is expected to be trustworthy, to protect the welfare of the client, and to do everything possible to help the client reach goals in a reasonable amount of time. Regardless of the intimacy and trust established in the relationship, a power hierarchy remains.

The therapeutic relationship is specifically developed to help the client seek and find solutions. Kottler, Sexton, and Whiston (1994) reviewed empirical, conceptual, and clinical literature across different disciplines such as psychology, social work, and medicine, and discovered the following:

Relationships are the forum for change to take place. Regardless of the theoretical orientation that is initiated or the techniques that are employed, it is the connection between the client and counselor that is the basis for all further work. The relationship has an explicit goal and purpose - to end it as soon as therapeutically possible. There is an understanding that one person, the counselor, has more

control, responsibility, and expertise in making things go smoothly and helpfully, whereas the other person, the client, is more important. (p. 98)

The relationship is mostly consisting of interpersonal influence in which the counselor attempts to promote change in the client. Theoretical relationships exist in a cultural context. These types of client/counselor relationships are likely to be more helpful when they are built in ways that respect the values, expectations, and needs of the client, along with one's cultural background: including ethnicity, socioeconomic class, religion, gender, and other relevant factors (Kottler, Sexton & Whiston, 1994).

The interactions are structured to make efficient use of time in the session. Small talk is typically avoided during counseling, where time is viewed as a valuable commodity. The therapeutic relationship can deal with a variety of human behaviors, thoughts, attitudes, and actions, but mostly focuses on the expression and exploration of feelings that are rarely disclosed outside of the encounter. Although Rogers (1980) core conditions are typically discovered within most theoretical approaches, some professional counselors believe they may not be enough to promote significant, lasting change. For the relationship to succeed, both client and counselor must come to an agreement as to the causes and etiology of the presenting complaints and what must be done to make things better. The most effective relationships are characterized by agreement on goals, consensus on methods, open communication, and a collaborative partnership (Kottler, Sexton & Whiston, 1994).

Kottler, Sexton, and Whiston (1994) asserted that:

The relationship is multidimensional. Most of the features described by various therapists play an important role in the process. Thus, therapeutic relationships

are, in part, authentic interactions, as well as projected experiences in which both client and counselor distort what is happening between them based on their respective unresolved issues. The relationship is dynamic and changes over time. What is most appropriate in the beginning stages of counseling is less important during the working stages when an interactional pattern has developed to accomplish therapeutic tasks. Likewise, when counseling is ending, a return to a more egalitarian relationship is more likely to be helpful than one that provided helpful at another stage. (p. 98)

Counselor/Child Therapeutic Relationship

Allowing the child to express self openly and freely is paramount to the success of the relationship and outcome of child-centered therapy. Learning how to facilitate an environment where the child can relax and grow all begins in the extraordinary therapeutic relationship established between counselor and child. Landreth (2002) listed some objectives that express the purpose of the child-centered relationship:

To establish an atmosphere of safety for the child. The play therapist cannot make a child feel safe. The child discovers that in the developing relationship. The child cannot feel safe in a relationship that has no limits. A feeling of safety is also promoted by the consistency of the therapist. To understand and accept the child's world. Acceptance of the child's world is conveyed by being eagerly and genuinely interested in whatever the child chooses to do in the playroom. Acceptance also means being patient with the pace of the child's exploration. Understanding is accomplished by relinquishing adult reality and seeing things from the child's perspective. To encourage the expression of the child's emotional

world. Although play materials are important, they are secondary to the expression of feelings by the child, which they facilitate. In play therapy, there is an absence of evaluation of feelings. Whatever the child feels is accepted without judgment. To establish a feeling of permissiveness. This is not a totally a permissive relationship. An important aspect, however, of play therapy is the child feels or senses the freedom available in this setting. Allowing the child to make choices creates a feeling of permissiveness. To facilitate decision-making by the child. This is accomplished largely by refraining from being an answer source for the child. The opportunity to choose what toy to play with, how to play with it, what color to use, or how something will turn out creates decision-making opportunities, which, in turn, promote self-responsibility. To provide the child with an opportunity to assume responsibility and to develop a feeling of control. Actually being in control of one's own environment may not always be possible. The significant variable is that children feel in control. Children are responsible for what they do for themselves in the playroom. When the play therapist does for children what they can do for themselves, children are deprived of the opportunity to experience what self-responsibility feels like. Feeling in control is a powerful variable and helps children develop positive self-esteem. (p. 175)

Adult Therapy Approaches

As mentioned earlier, the primary method of conducting therapy with adults is that of a verbal exchange. Client talks; counselor listens and responds. Every clinician's style of conducting counseling is different to certain degrees and depends on such factors as personality, theoretical orientation, setting, and experience. But, research does, indeed,

support certain universal elements such as that the therapeutic relationship, collaboration, and positive expectations from the client will lead to growth and change (Brammer, Abrego, & Shostrum, 1998).

Research shows the ultimate variables in successful treatment outcome lies within the clients and their severity of disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and ability to identify a focal problem (Lambert & Cattani-Thompson, 1996). Certain client variables can change early in the counseling process, such as motivation and expectations for improvement, whereas other client variables, like personality styles, are relatively immutable, especially in short-term therapy. Mindful counselors should be able to familiarize themselves with the important client variables, with how to conceptualize and assess them, and with how to utilize therapeutic approaches that will allow changes to realistically occur (Garfield, 1991).

As the counselor is formally educated and begins work with clients, it is the counselor's decision to choose which theoretical model to implement. Different theories have different tenets and approaches. Client-centered theorists believe the nurturing relationship between client and counselor plays the most significant role in promoting change. Behaviorists believe reinforcement, structured practice, and modeling lead to significant change. Advocates and agents of Freud's Psychoanalytic Theory focus on unconscious desires, whereas constructivists emphasize different perceptions of reality. Cognitive counselors believe therapy works by teaching clients to think more logically and rationally (Kottler, 2004).

The primary reason research findings declare counseling to be an effective process, regardless of the variety of diverse counseling methods, is because different

therapies embody common elements (Lambert & Cattani-Thompson, 1996). These common factors across different treatment modalities account for a substantial portion of improvements found in psychotherapy clients. The common elements that received the most researched support make up the core of client-centered counseling: strongly emphasizing empathy, warmth, and positive regard. These are the primary factors that embody the therapeutic relationship (Lambert & Cattani-Thompson, 1996). Therapeutic approaches other than client-centered theory use different terminology such as acceptance, tolerance, therapeutic alliance, working alliance, and support - - all client-centered characteristics -- thus making it abundantly clear that virtually all theories utilize and accept the importance of counselor-client relationship variables.

A study by Lafferty, Beutler, and Crago (1991) reported on the significance of empathy as a factor in counseling outside of the client-centered modality. These researchers were attempting to determine what differences neophyte counselors displayed that differentiated them as being more or less effective. Reports determined the counselors who were the least empathic had the most clients that manifested more distress after, than before, treatment.

Researchers have conducted an impressive amount of investigation on client-centered factors within almost all therapeutic approaches. They have also arduously explored the significance of the therapeutic alliance, or relationship, as a condition necessary for client change. Clients continually report importance of the counselor rather than techniques (Lambert & Cattani-Thompson, 1996).

Lazarus (1971) conducted a study in his behavior-oriented practice. Over 100 clients were interviewed and asked to indicate their perceptions of effects and desirability

of treatment, expressing what was most important. What turned out to be most valuable were the actual therapists as people and characteristics they possessed, not distinguishing methods used. When describing their counselors, clients used terms like gentle, honest, and sensitive. Personal qualities of counselors clearly superseded specific technical factors. Actually, there was minimal if any agreement about helpfulness of any particular techniques.

Slone, Staples, Cristol, Yorkston, and Whipple (1975) led an acclaimed study that attempted to determine what therapeutic factors lead to positive results. They distributed a survey four months after treatment to clients of both behavior and psychodynamic therapies. Items included specific techniques of both schools of therapy as well as other elements thought to be present in both. For successfully treated clients, primary importance was placed mostly on these same items. Over 70% of clients rated the following five items as "important" to "extremely important" in facilitating their improvement: personality of the counselor, counselor helping them to understand their problems, encouragement, talking to an understanding person, and the counselor helping with greater self-awareness. No participants described a technique. This study also found from clients' points of view, elements associated with relationship variables, self-understanding, and active involvement are conspicuous variables of change.

Lafferty et al. (1991) conducted an alternate study that investigated the relationship of counselor characteristics to counseling outcome by comparing effective versus ineffective therapists. Effectiveness was measured by the pre to post-treatment change that occurred during counseling. Variables of interest included: degree of counselor's emotional adjustment, relationship attitudes such as empathy, client's active

involvement in treatment, support and directiveness from counselor, credibility of counselor and counseling, theoretical orientation, and certain values held by both counselor and client.

Researchers' conclusions indicated counselor empathy as the most predictive of whether the counselor was effective or ineffective, a finding persistent throughout past research (Lambert & Cattini-Thompson, 1996). The outcome also displayed that "effective therapists" showed more support towards their clients and placed an emphasis more on intellectual values such as reflection. "Ineffective counselors" emphasized terminal values, such as having a comfortable and/or exciting life (Lambert & Cattini-Thompson, 1996).

Although the therapeutic relationship is paramount to successful treatment of most clients, research indicates for specific issues and disorders, unique interventions can promote client wellness (Lambert & Cattani-Thompson, 1996). For example, evidence suggests treatment of panic disorders is most successful when a cognitive-behavioral intervention is applied. When treating phobic disorders, numerous behavioral techniques that include some type of systematic exposure have been shown to be highly effective (Emmelkamp, 1994).

Although studies demonstrate instances in which specific techniques have particular effects on particular disorders, more evidence exists for the conclusion determining there is little variance between theories of counseling's ability to generate substantial positive differences in client outcome (Lambert & Cattani-Thompson, 1996).

Kottler (2004) stated that regardless of work settings, theoretical orientation, graduate educational programs, and client population, effective counselors tend to use similar intervention skills. He divided these skills into several broad categories:

1. Diagnostic skills. This involves questioning and assessment strategies to determine what the client is suffering from and formulate a helping plan.
2. Exploration skills. This is used to understand the client's world and collect needed information that will be helpful in later efforts.
3. Relationship skills. This works to build a supportive alliance with the client and be conducive to openness, trust, and respect.
4. Understanding skills. This helps to promote self-awareness and deep-levels investigations into the nature of presenting concerns and the larger meanings.
5. Action skills. This helps translate identified problem areas and new understanding into sequential steps towards desired goals.
6. Group process skills. This is employed in family, organizational, and consultation settings to resolve conflicts and work towards team objectives.
7. Evaluation skills. This is used to measure the effects of intervention efforts, and, if necessary, make adjustments.

Effective counselors are also knowledgeable in helping individuals to anticipate concerns and issues, respond constructively, develop adaptive life skills, and move towards personal growth and increased personal mastery. Kottler (2004) listed a common set of goals for counselors to adhere to when working with adults:

1. Work constructively toward life/career planning.
2. Anticipate, plan, and react constructively to developmental issues and transitions.

3. Integrate thinking, feeling, and behavior into a congruent expression of self.
4. Respond productively to stress and reduce its negative impact on one's life.
5. Develop effective interpersonal skills so relationships with peers, family, and colleagues can have constructive potential.
6. Assess strengths and identify weaknesses so personal awareness may develop.
7. Become aware of the holistic nature of life and integrate effective principals of living into psychological, physical, and social aspects of their lives.
8. Develop more choices in with accompanying skills to make constructive decisions.
9. Become independent of counseling in the shortest time possible.

Child-Centered Play Therapy History and Educational Roots

Child-Centered Play Therapy

The onset of the child-centered model stems from Allen (1934), whose relationship approach did not seek to change or "fix" the child. The primary principle of this approach is to accept the child as is. Allen stated:

It is indicative of my respect for his capacity to work on his problems, and to achieve a healthier expression of himself through the type of relation I enable him to have with me as a therapist. If I can create a relation in which the child or adult feels that he is accepted at the point he is in growth - - rebellious, hostile, fearful, or what not - - then that person has an opportunity to go ahead with those difficulties that are most concerning him. (p. 196)

A second principle Allen followed was understanding the limitations of the counselor, and a third principle was recognizing the value of the therapeutic relationship. He did not see any therapeutic value in utilizing facts that have been acquired from

others, and he saw no value in making the child discuss anything the child did not want to discuss. Allen believed the job of the counselor was to create a natural relation in which the child can acquire an adequate acceptance of self and a clearer conception of what can be done, felt, and achieved in relation to the world in which one lives (Allen, 1934).

A pediatrician and founder of child psychology and psychotherapy, Margaret Lowenfeld (1969), employed a completely non-directive approach. She created non-verbal techniques that allowed children to communicate their thought processes and emotional responses without having to talk. She understood from early on that spoken language was often an unsatisfactory medium for children to express experiences.

H. G. Wells, the famous science fiction writer, wrote a book titled *Floor Games* (1976), in which he described the fantastic worlds children can create by arranging small models and objects to create scenes that might be meticulously realistic or wildly imaginative. He described in detail the materials needed to create these worlds. He and his sons built scenes on the floor that became the stage for dramatic, imaginative play. Lowenfeld was directly inspired by Wells' writing and stocked her therapy room with hundreds of miniature objects, animals, and human figures. She also added large metal trays of sand that were placed on waist-high tables, enabling children to utilize the sand to further create their scenes. Lowenfeld (1969) believed the miniature objects and figures established a significant bridge between observations of the therapist and children's inner beings. Becoming acutely aware that children's play ascends more naturally and spontaneously when void of adult tampering, Lowenfeld allowed children free reign in the playroom (Pottkotter, 2003).

Virginia Axline was a student of Carl Rogers, the founder of non-directive therapy. She took his concepts and expanded them into the child realm, making no effort to control or change the child. Non-directive play therapists are indoctrinated in the foundational belief that the child's behavior is always caused by the drive for complete self-realization.

In summarizing her concept of play therapy, Axline (1950) stated:

A play experience is therapeutic because it provides a secure relationship between the child and adult, so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time. (p. 68)

Axline agreed with Allen (1934) in that although the role of the counselor is non-directive, it is not passive or inactive. She believed the counselor requires alertness, sensitivity, and an ever-present appreciation of what the child is doing and saying.

The playroom is fully stocked with toys and objects of activity, and the child is free to use the toys in almost as many ways as one could imagine. The counselor actively reflects the client's thoughts and feelings, believing that as the child understands one's feelings, forward movement occurs. The client is free to deal with all cognitions and emotions (Landreth, 2002).

Emotions of children are an essential component of human nature, growing and expanding throughout childhood. Relating to the physical and social environment, emotions represent a major component of human biological and cultural heritage. Emotions sensitize individuals to interesting and challenging features of the social and

physical environment, defining the quality of human experience and creating the basis for temperament and personality (Landreth, 1993).

Moustakas (1959) discussed relationship play therapy and defined the relationship needed to insure counseling is a growth experience, particularly relative to the need for the counselor to respect and accept the child. He identified four stages in the therapeutic process:

1. The child's emotions are diffused and emotions are generally negative.
2. The relationship develops, attitudes of hostility become more specific, and anger is expressed against particular people and experiences. As the negative feelings are expressed and the counselor accepts them, they become less intense.
3. The child becomes less negative. One still has anger, but is no longer ambivalent towards the people in one's life.
4. Positive feeling emerge. The child sees self and the relationship with others in a more balanced way. Levels of the process occur in individually varying sequences with some overlapping. Key elements in this method are the security of the child with the counselor.

Moustakas (1959) also believed conditions necessary for self-actualization to occur through non-directive therapy can be characterized by three elements or core conditions:

1. Genuineness and authenticity - the capacity to be real, to be oneself, as opposed to adopting a role or defensive posture with the client.
2. To have non-possessive warmth - an attitude of caring and engagement and friendly concern without becoming emotionally involved or offering help for self-serving reasons,

3. Accurate empathy - the ability to feel with those who are seeking help and to articulate these feelings.

Child-centered play therapy is heavily rooted in Carl Rogers' (1951) Person-Centered Theory; therefore, many of the child-centered theory tenants are noticeably similar to Rogers' approach to counseling. Rogers (1961) conducted a study in which expert therapists, those rated effective by clients were able to establish and maintain relationships with their clients that consisted of three essential components: sensitivity to the client's attitudes, understanding the client's feelings and perceptions, and the ability to show a warm interest without becoming too emotionally involved. He also stated counselors should be consistently dependable, communicate unequivocally with the client, experience a positive attitude towards the client, see the world through the client's eyes, refrain from engaging in external evaluation, and not allow the client's past to define the person.

Rogers (1980) stated children come to rely on their own vast resources for self-directed behavior and for altering self-concept and basic attitude. As a result, power to change lies inside children and is not a result of direction, advice, or information from the counselor. Rogers' focus was on the relationship between clients and counselor, in which children can discover their self-capacity and use that relationship for growth and change resulting in personal development. The relationship is, in itself, therapeutic.

Child-centered play therapy is more of a way of being rather than certain techniques. Schaefer and O'Connor (1993) noted the counselor who practices client-centered play therapy must express an attitude of being completely with the child as an emotional and verbal participant. The counselor must be open to the child's experiences

and convey the crucial messages of "I am here with you," "I hear you," "I understand you," and "I care about you."

This theory states that children possess a certain innate capacity to strive towards growth and maturity. The relationship established between counselor and young clients anchor what allows their growth, experience, and ability to become self-directing. Children are given the freedom in the therapeutic relationship to completely be themselves in the process of working out feelings and experiences.

A major goal of the counselor is to create a relationship and environment that will facilitate children becoming self-directing, able to explore all feelings and thoughts, self-responsible, creative, and functionally adaptive. Child-centered play therapy is a way of being with children rather than a way of doing something to or for children (Landreth, 2002).

The child-centered play therapist attempts to create an environment in which the child can feel completely safe, a permissive situation that is void of criticism, suggestions, praise, disapproval, or attempts to change the child. There is no need to please the adult counselor. There are therapeutic limits, but they are carefully implemented and allow the child to learn self-control and responsibility (Landreth, 2002).

By way of the play therapist's cultivated, distinctive empathy and understanding, one could reflect the child's issues and turmoil. The therapist becomes a dependable and enduring object in whom the child can rely (Axline, 1969).

Axline (1982) also stated there are some basic personal characteristics that are requisite for a nondirective play therapist to be effective: interest in the child, respect for the child as a person, patience, willingness to understand the world from the child's

perspective, insight into self needs, flexibility, a light touch, sensitivity, empathy, emotional stability, consistence, a willingness to flow, and trust in both the child and the therapeutic process.

Via the established relationship between counselor and client, a safe atmosphere is purposefully created, allowing the emergence of very intense and important affects, helping the client work through these affects until they no longer become overwhelming and flooding (Chethik, 2001).

Ginott (1982) believed play therapists need to be able to tolerate situations that are noisy, messy, destructive, and lacking order. He stated counselors who have a need for order and self-restraint waste a significant amount of energy trying to balance the reactions that are elicited in them in the playroom, stealing their ability to fully accept the child.

Toys in the playroom should suggest durability rather than send a fragile message to the child. The toys should facilitate a wide range of creative and emotional expression, engage the child's interest, facilitate expressive and exploratory play, and allow success without verbalization. Toys need to be carefully selected, not randomly collected. The toys and materials are an essential part of the experiential and communicative process for the child (Landreth, 2002).

Past experiences, no matter how benign or how painful, can be expressed more easily and safely by means of symbolic use and representations the toys present. The ability to use toys allows children to transfer feelings of guilt, shame, anxiety, and fear to objects rather than people. This transference permits the young clients to distance themselves from traumatic events and experiences (Martin & Caro, 1985).

Child-Centered Methods

This section briefly describes methods and approaches that are uniquely applied in child-centered play therapy. Entire books have been written describing the child-centered approach; therefore, I will attempt to concisely convey what comprises the fundamental tenets of this theory, beginning with the role of the counselor.

The child-centered counselor's job is to facilitate the child's growth. Evident in child-centered play therapy more than any other therapy, the counselor grants the child the freedom to be one's self without facing evaluation or pressure to change. The child is offered the opportunity to experience growth in the most favorable conditions by playing out feelings as they are brought to the surface. The child can choose to face them, abandon them, or learn to control them. By this unique atmosphere and ability to choose, the child becomes more psychologically mature and begins to realize selfhood (Axline, 1947).

Most behaviors of child-centered play therapists are designed to facilitate the child's self-direction, self-exploration, and self-growth. Child-centered play therapists react to the child as opposed to initiating one's own actions. The quickest avenue to optimal development is meeting the child's emotional needs as the child is currently experiencing them and furthering their overt expression (Guerney, 1983).

Landisberg and Snyder (1946), examined child and counselor session behavior consisting of verbal and non-verbal responses. They also measured significant responses, that is, what behaviors of the counselors preceded child behaviors. Three-fifths of all responses were made by the child; two-fifths were made by the counselor. Non-directive responses preceded 85.5% of the child's responses, with 57% reflection of feeling. Empathic responses and structuring tended to precede action responses from the children.

Less than 10% of counselor responses were simple acceptance, showing that there is more to nondirective (child-centered) therapy than basic acceptance. Throughout therapy, children increased the amount of feelings through action expression from 50% to 70%.

Guerney (1983) stated child-centered play therapists should adhere to certain concepts and tenets to become competent counselors. She believed new counselors might have the tendency to be lured into behaviorist methods. Adherence to the child-centered approach needs to be reinforced, and supervision and education must be rigorous and supportive. Empathic understanding and a nonauthoritarian attitude towards children are extremely important traits.

Solt (2003) contended other problems can arise during play therapy training. As the novice counselor begins to realize employing play therapy methods entail possessing and utilizing both personal and technical skills, one tends to lose sight of the importance of the counselor in the process. Yet, over the course of time, child-centered counselors are ideally able to reach therapeutic maturity by becoming privy to their humanness, strengths and weaknesses, importance of their presence in sessions, and awareness or insight into their own development.

Child-centered theory places massive importance on the ability for counselors to be empathic. Linden and Stollak (1969) investigated if undergraduate psychology students could discern how to behave in a sensitive, empathic way to children receiving nondirective training in play therapy, as opposed to didactic training in play therapy. The results displayed that while some individuals are naturally more empathic, the ability to communicate empathy is a dimension that must be learned. In other words, having

empathy for a person is, alone, not enough; a counselor must also be able to convey this empathy.

Because specific methods for handling particular types of maladjustments are generally not required, no goals are set by the counselor beyond reducing the negative symptoms and replacing them with evidence of emerging self-acceptance, independence, and acceptance of others. In other words, the behavior of the child-centered play therapist is essentially the same regardless of the presenting symptoms. The counselor believes the special atmosphere created permits the child to normalize one's own behavior, regardless of whether the problem is an excess or deficiency on the relevant dimension.

The verbal behaviors of child-centered play therapists are primary tools in counseling. Empathic responses are typically referred to as reflection of feeling and reflection of content, demonstrating an understanding of where the child is and what is being experienced. Child-centered play therapists are also taught to respond empathically to thoughts and actions as well as feelings. Understanding a child's non-verbals and reflecting the feeling beneath helps the child feel understood and accepted. A child will not offer feelings or thoughts readily as an adult might; therefore, the child-centered counselor learns to focus on all features of what the child emits. The counselor's personal thoughts must be delegated to the background while all attention is completely focused on all aspects of the child. An attitude of total receptivity expressed with eye contact, facial, muscular, and postural attentiveness must prevail (Guerney, 1983). The play therapist is an adult who empathically listens, intentionally observes, and is encouraging as the child's wants, needs, feelings, and play are all recognized. The child receives the counselor's complete attention (Landreth, 2002).

Child-centered counselors maintain a level of structure for the child. The reason is to provide a certain amount of information so the child will know what to expect from the counselor concerning the time and place within the sessions. The goal of structuring as a therapeutic response is to give information, or the arranging of the environment, to facilitate situation-appropriate responses from the child. How long the session is, where the child goes afterward, how often the sessions take place, and length of sessions are all examples of structuring (Guerney, 1983).

Limit setting is another component of child-centered therapy. Limits are imposed to help the child understand the areas in which to operate. Limits allow the counselor to remain empathic and accepting while helping the child build self-control to stay within the defined boundaries. Playroom limits are minimal but very clear, definable, and enforceable. They are imposed to protect the child and counselor alike (Guerney, 1983).

Concerning counselor involvement in the child's play, Guerney (1983) believed as long as the child is the major object of importance, all thoughts and feelings are accepted in the session; there is consideration of where the child is, what the child thinks, fantasizes, or acts out, and it is acceptable to involve one's self in play as long as the counselor is invited by the child. The counselor should follow the child's lead and be available to become an active participant. The counselor can easily respond in role-playing and activity sharing without taking over. Regardless of the level of requested involvement, it is important for the counselor to remember not do for the child what the child can do for one's self.

Although the counselor does not solve problems for the child, explain behavior, interpret motivation, or question intent, all of which would rob the child of self-discovery,

these exclusions do not imply a passive role. The counselor is extremely active emotionally, which requires sensitivity, an appreciation of what the child is saying and doing, and an attitude of receptive responses. The counselor's role is not to reshape the child's life or make one change in some predetermined way but to respond in ways that facilitate the release of creative potential that already exists within the child. Through the strength of the created relationship, allowing the youngster to communicate freely, child-centered play therapist believe growth and self-responsibility will flourish (Landreth, 2002).

Interestingly, Solt (2003) discovered that play therapists possess certain characteristics that are not as prevalent in non-play therapists. According to her study, students educated in play therapy tended to be less extraverted. Specifically speaking, a significant difference was found in the Gregariousness Scale on the NEO Personality Inventory-Revised, indicating play therapists tended to be less gregarious than non-play therapists. She also discovered play therapists tend to like children more.

The play therapist is a unique adult in the child's life. Landreth (2002) stated the counselor responds out of humanness to the child while controlling any desire to direct, probe, or teach. He also believed the attitude of the counselor sets the tone of the session and permeates the entire session. Axline (1969) believed the counselor is not a playmate, a teacher, or a substitute parent. The accomplished therapist is learned to act more as a sounding board against which the child can try out one's own personality, assume responsibility, become self-directing, and develop individual identity.

CACREP

The Council for Accreditation of Counseling and Related Educational Programs (CACREP), a specialized accrediting body recognized by the Council for Higher Education Accreditation (CHEA), has conferred accreditation to the following program areas in Counseling at the university used in this study: community counseling (M.Ed., M.S.), school counseling (M.Ed., M.S.) (elementary or secondary), college and university counseling (M.Ed., M.S.), and the Ph.D. in counseling.

The CACREP standards (2001) are to provide leadership and to promote excellence in professional preparation through the accreditation of counseling and related educational programs. As an accrediting body, CACREP is committed to the development of standards and procedures that reflect the needs of a dynamic, diverse, and complex society. CACREP is dedicated to (1) encouraging and promoting the continuing development and improvement of preparation programs, and (2) preparing counseling and related professionals to provide service consistent with the ideal of optimal human development. Accredited counseling master's programs are required to follow certain standards to keep their accreditation. These standards include, but are not limited to, 48 semester hours of graduate studies, specific curricular experiences, and demonstrated knowledge in common core areas. The common core curricular experiences include the following areas:

- a. Professional Identity
- b. Social and Cultural Diversity
- c. Human Growth and Development
- d. Career Development

- e. Helping Relationships
- f. Group Work
- g. Assessment
- h. Research and Program Evaluation

Practicum and internship experiences are required for all students as well as demonstrated knowledge of ethical standards of the American Counseling Association and related entities, and applications of ethical and legal considerations in professional counseling.

The list of CACREP standards (2001) is extensive and exhaustive, but it is important to note that there is no requirement for play therapy. Although CACREP does require knowledge of theories of individual and family development, along with theories of learning and personality development, including an examination of the historical development of counseling theories, an exploration of affective, behavioral, and cognitive theories, there is no direct requirement for students to display or learn fundamental counseling relationship building skills, including non-verbals or body language, nor a requirement to gain specific working knowledge or skills when counseling children. What CACREP does require is more general-skills based, asking for an understanding of essential interviewing and counseling skills so that the student is able to develop a therapeutic relationship and establish appropriate counseling goals.

CACREP Clinical Instruction

Clinical instruction includes supervised practica and internships that have been completed within a student's program of study. Practicum and internship requirements are considered to be the most critical experience elements in a counseling program. This

study is measuring client outcomes, taken from assessments administered during the play therapists' and non-play therapists' practicum. Practicum includes:

1. Forty hours of direct service with clients, including experience in individual counseling and group work;
2. Weekly interaction with an average of one (1) hour per week of individual and/or triadic supervision which occurs regularly over a minimum of one academic term by a program faculty member or a supervisor working under the supervision of a program faculty member;
3. An average of one and one half (1 1/2) hours per week of group supervision that is provided on a regular schedule over the course of the student's practicum by a program faculty member or a supervisor under the supervision of a program faculty member; and
4. Evaluation of the student's performance throughout the practicum including a formal evaluation after the student completes the practicum.
5. Group supervision for practicum and internship should not exceed 10 students.
6. Clinical experiences (practicum and internship) should provide opportunities for students to counsel clients who represent the ethnic and demographic diversity of their community.
7. Students formally evaluate their supervisors and learning experience at the end of their practicum and internship experiences.
8. Programs require students to be covered by professional liability insurance while enrolled or participating in practicum, internship, or other field experiences.

Summary

Play therapy is currently recognized as a powerful therapeutic medium in the world of counseling and psychotherapy (Coleman, 2001). As individuals move through life, the ability to play tends to add to the human experience. The relationship established between counselor and client appears to be essential in the outcome of successful versus unsuccessful therapy. The building of the therapeutic relationship between adult clients and counselors tend to look somewhat different than child/counselor relationships; adults and children communicate and operate differently (Landreth, 2002).

Child-centered play therapists are taught unique and special skills to form therapeutic relationships and conduct therapy with child clients. The methods of child-centered play therapists move to facilitate child's self-direction, self-exploration, and self-growth. Child-centered play therapists respond to the child; they do not impose their own agendas. As the child experiences the non-evaluative, freeing environment created by the genuine, caring, and prizing counselor, the therapeutic relationship develops (Landreth, 2002). Adult therapy methods tend to vary, although most contemporary theories recognize the value of relationship building and Rogers' core conditions, individual counselors are typically given the opportunity to choose which approach to take when counseling their clients (Zimmerman, 2003). Child-centered play therapists learn an unprecedented approach to relationship building, along with methods to respond and reflect all facets of the child, including non-verbals, facial expressions, body language, and verbal expressions.

The counseling program used in this study meets all CACREP standards. CACREP is a specialized accrediting body that provides leadership and promotes excellence in

professional preparation through the accreditation of counseling and related educational programs. A few elements of counseling CACREP does not specifically address or require is knowledge in play therapy, working specifically with children, nor a detailed, working display of skills in detecting and responding to non-verbals. In this study, I examined the extent to which counselors with play therapy training were more effective with adult clients than were those not so trained. A positive finding would suggest the inclusion of a play therapy component in all counseling programs and in CACREP standards.

CHAPTER 2

METHODS AND PROCEDURES

In the previous chapter, I reviewed the literature pertinent to: play therapy, counselor/adult therapeutic relationship, counselor/child therapeutic relationship, adult therapy approaches, child-centered play therapy history and educational roots, child-centered play therapy methods, and Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards. The purpose of this study was to add to existing empirical data on educational factors as they relate to counselor effectiveness. Therefore, in this study, I attempted to determine the extent of client outcomes, inferred from the specialized methods child-centered play therapists possess when working with an adult population, using child-centered philosophy of play therapy relationship-building techniques and methods.

Research shows the most important factor in therapeutic change is strength of the relationship between client and counselor (Asay & Lambert, 1999). Individuals who are educated in child-centered play therapy are specifically taught unique and specific relationship fostering skills and may possess increased, knowledge and technique in client/counselor relationship building and therapeutic methods. With this study, I hoped to add to current research and understanding of whether child-centered play therapy education of counselors who see adult clients will significantly effect adult client behavioral change.

Research Question

After undergoing 10 sessions of counseling, will adult clients of counselors educated in child-centered play therapy report significantly greater positive behavioral change than adult clients of counselors not educated in child-centered play therapy?

Research Assumption

Adult clients who receive counseling from child-centered play therapists will report greater positive behavioral change than adult clients of non-educated play therapists, as demonstrated by client outcome assessment measures.

Methods

Research Design

Quantitative research is designed to classify features, count them, and even construct more complex statistical models in an attempt to explain what is observed. Findings can be generalized to a larger population, and direct comparisons can be made between two corpora, as long as valid sampling and significance techniques have been used. Thus, quantitative analysis allows a researcher to discover which phenomena are likely to be genuine reflections of behavior and which are merely chance occurrences. The more basic task of looking at only a single language variety allows one to get a precise picture of frequency and rarity of particular phenomena and, thus, their relative normality or abnormality. For this study, all aspects were carefully designed before data were collected. Researcher used the Adult Self Report (ASR) symptom assessment to collect numerical data in the form of frequencies, scores, numbers, and statistics (Howell, 1997).

Participants

Research participants consisted of two groups. The first group was 30 adult clients who underwent counseling sessions with 30 practicum student counselors educated in play therapy. The second group was 30 adult clients who underwent counseling with 30 counselors not educated in play therapy. For this study, each adult client was seen by one practicum student counselor, either a play therapist or a non-play therapist, and was measured on the Adult Self-Report before and after treatment -- the pre-test and post-test, respectfully. All counselors have worked with adult clients in their pre-practicum experience at a major university's counseling program in the southwest United States, and were working w/one or more other adult clients prior to and/or concurrent with their research client. All counselors have counseled at least two adults over the course of the research semester.

Counselors were selected based on similar graduate coursework, enrollment in Master's practicum, and similar clinical experience. Master's practicum followed CACREP requirements listed earlier in this study. The only known difference between counselors was that one group was formally educated in child-centered play therapy, whereas the other group was not.

The child-centered play therapists had received additional education and experience in play therapy methods through completion of one three-credit semester course - an introduction to play therapy class. The course covered a substantial amount of material for students to develop an integrated understanding of children's developmental communication; to acquire the necessary play therapy skills needed to facilitate children's expression, development, self-understanding, and personal growth; and to

establish and hone relationship-building techniques. Students were also required to observe and participate in supervised experiences in play therapy. The play therapy course's methods of instruction included discussion, role-playing, lectures, small group experiences, films, demonstrations, reading in the field, writing exploratory papers, observing play therapy sessions, and conducting play therapy sessions in which they were supervised by experienced play therapists. See Play Therapy Syllabus Appendix A for reference to detailed course requirements.

Both groups of counselors were enrolled in an accredited CACREP Master's counseling program. Master's CACREP core coursework for both groups of counselors were nearly identical with the exception of the play therapy course. All practicum counselors were required to take and pass the following courses to be eligible to enroll in practicum: counseling theories, basic counseling skills, educational statistics, lifespan human development, career development information and resources, counseling diverse clients, biopsychosocial assessment and wellness, group counseling theories and procedures, and advanced counseling skills. Depending on which track each counselor was enrolled, requirements varied concerning an assessment class. Community counseling track students preparing to specialize in counseling adults or children and adolescent were required to take a community counseling course along with appraisal in adult counseling or appraisal in child and adolescent counseling, respectively. School counseling track students counselors were required to take either an elementary school or secondary school counseling course along with appraisal in child and adolescent counseling. Clinical experience was consistent between the two groups of counselors, aside from the clinical component of the play therapy course. All practicum students had

the opportunity to enroll in an adolescent, couple, biofeedback, or parent/family counseling course as an elective. Each of these courses contain a small, specialized clinical component.

According to clinic procedures, 60 research participant clients (respondents) of the Master's level counselors were, unbeknownst to them, assigned to a counselor, without regard to whether or not the counselor was a play therapist. Thirty clients were seen by play therapists; 30 other clients were seen by non-play therapists. All clients consisted of university students, voluntarily and seeking extra credit for attending counseling, and clients from the community, also voluntarily seeking counseling services. Both groups were composed of adults at least 18 years of age. No exclusion of potential research participants was made on the basis of any demographic variable except majority age.

Instrument

Self-report of psychological status is a measurement modality widely used. Particularly in the areas of psychological distress and psychopathology, self-reports provide information that is unavailable through other assessment modalities. The self-report approach has the unique advantage of deriving data from an individual's "experiencing self", that is to say, the person actually centered in the phenomena. External observers cannot completely relate to this experience except through its public manifestations and are limited to reporting ostensible renditions of the subjects experience based solely on behavior and verbal reports. Self-reporting lends itself to the respondent's opinion with all of one's biases that are most relevant for the approach and maintenance of treatment (Derogatis, 1994).

Self-report assessments have also emerged as the most common means of operationally delimiting normality versus abnormality via its implementation in defining psychiatric illness. For these reasons, data gleaned from self-report assessments have been incorporated into a wide spectrum of clinical decision and outcome measurement systems. Massive research and time spent honing and critiquing current self-report measures has insured this type of psychological distress and symptomology assessment its status as a pivotal method of contemporary clinical/outcome evaluation (Derogatis, 1994).

Multidimensional assessments significantly enhance breadth of measurement compared to unidimensional scales, usually with minimal loss of reliability. When evaluating psychopathology, multidimensional measurements deliver a meaningful syndromal complex within which to interpret the scores on any particular symptom dimension of interest, such as anxiety or depression. The respondent's status is further elucidated and amplified by data concerning discrete symptoms which help to represent and specify in detail the nature of the individual's psychological distress status (Derogatis, 1994).

Adult Self-Report

The primary assessment used was the Adult Self-Report (ASR); (Achenbach & Rescorla, 2003) for ages 18-59 years old. Based on at least 15 years of research, the ASR incorporates many new items of the 1997 edition of the Young Adult Self Report (YASR) plus new items and new national norms that span ages 19-59 years old.

The profiles for scoring the ASR include normed scales for adaptive functioning, empirically based syndromes, substance abuse, internalizing, externalizing, and total

problems. The following derived syndromes are Anxious/Depression, Withdrawn, Somatic Complaints, Thought Problems, Attention Problems, Aggressive Behavior, Rule-Breaking Behavior, and Intrusive.

The ASR also contains scales for Substance Use, Critical Items, Internalizing, Externalizing, and Total Problems. In addition, the ASR profiles feature new *Diagnostic and Statistical Manual for Mental Disorders-IV-TR (DSM-IV-TR)*; (2000), oriented scales consisting of items that experts (psychiatrists and psychologists) from 10 different cultures identified as being very consistent with particular concern to clinicians. The profiles display scale scores in relation to norms for each gender based on national probability samples. The *DSM-IV-TR* oriented scales are Depressive Problems, Anxiety Problems, Somatic Problems, Avoidant Personality Problems, Attention Deficit/Hyperactivity Problems, and Antisocial Personality Problems.

The ASR sections pertaining to adaptive functioning have recently been revised to provide greater differentiation in assessing friendships, occupational functioning, and relationships with spouse or partner and other family members. Several new items were added for assessing problems, and some poorly performing YASR items have been omitted (Achenbach & Rescorla, 2003).

The ASR also assesses demographic information about the respondent. Information about occupation and education is requested for scoring socioeconomic status. The adaptive functioning items are displayed on pages one and two. Pages three and four request ratings of behavioral, emotional, and social problems, plus socially desirable items that are endorsed by most people. These pages also request respondents to describe problems they rate. For example, details provided by respondents for item 9 - *I*

can't get my mind off certain thoughts - can provide clinically useful information that can be queried from further interviews. At the conclusion of page four, respondents are asked to indicate how many times a day they use tobacco, plus how many days they were drunk and how many days they used drugs for non-medical purposes during the preceding six months. The answers to these items are scored on normed scales for substance abuse (Achenbach & Rescorla, 2003).

ASR Mean Adaptive Score

To provide a global estimate of adaptive functioning, the *t*-scores of all the adaptive functioning scales scored for a subject are averaged to acquire the Mean Adaptive score. Two reasons for averaging the *t*-scores rather than summing the raw scores are:

1. Respondents acquire scores on only those scales that pertain to them over the past six months.
2. The different number of scales scored for different participants and the different ranges of raw scores on each scale would produce sums of the raw scale scores to be differently affected by the particular scales scored for each respondent.

By averaging the *t*-scores, users acquire a mean score that summarizes the subject's adaptive functioning across scales scored for that respondent. After computing the Mean Adaptive score, users can mark the obtained score for the respondent's gender. The *t*-scores and percentiles enable one to evaluate the subject's Mean Adaptive score in relation to scores obtained by the national normative sample. Low scores on the adaptive functioning scales and the Mean Adaptive Scale are clinically relevant, because they indicate poor adaptive functioning (Achenbach & Rescorla, 2003).

Substance Use Scales

Similar to the Mean Adaptive score, a Mean Substance Use score is computed by averaging the *t*-scores for the Tobacco, Alcohol, and Drug scales. Dissimilar to the adaptive functioning scales, high scores on the substance use scales are clinically important, because they indicate high levels of substance use (Achenbach & Rescorla, 2003).

Critical Items Scale

As stated earlier, 10 mental health experts, specifically psychiatrists and psychologists from 10 different cultures, identified adult problem items that are extremely consistent with *DSM-IV-R* categories. They also rated each problem item according to problems at which clinicians might be particularly concerned, whether or not items are included in diagnostic criteria. Items were rated: 0 = not critical; 1 = possibly critical; and 2 = definitely critical. The 19 items ranked as definitely critical by $\geq 62\%$ of the clinicians comprise a Critical Items scale. The critical items are marked with a "c", and also marked on profiles that show the syndromes scored from the ASR (Achenbach & Rescorla, 2003).

The ASR Syndrome Profile

A syndrome is a set of problems that tend to occur. A statistical analysis for a large number of individuals of early ASR subjects was conducted to determine which problems tended to occur together. Based on those findings, eight syndrome scales were constructed. The title of each of the syndromes (Anxious/Depressed, Withdrawn, Somatic Complaints, etc.) summarizes the kinds of problems that form the syndrome.

Unlike scores on the adaptive functioning scales, high scores on the syndrome scales indicate clinically important deviance, because they reflect numerous problems. By computing the total score for each syndrome scale, one can see how the respondent compares with the normative sample on each scale. The computer readout indicates a line that highlights the syndromes on which the respondent has low scores, intermediate scores, and high scores. A major advantage of using computer scoring is that up to eight ASRs can be efficiently scored and compared for each client. This process is especially useful for evaluating similarities and differences between clients' views of themselves and other's views of them (Achenbach & Rescorla, 2003).

DSM-IV-TR Oriented Scales

The procedures for constructing the *DSM-IV-TR (DSM)* oriented scales for the ASR were as follows:

1. The descriptive criteria for the following *DSM* diagnostic categories were reproduced: Depressive Disorders, Anxiety Disorders, Attention Deficit Hyperactivity Disorder, Avoidant Personality Disorder, Anti-social Personality Disorder, Obsessive-Compulsive (including Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder), Schizotypal Personality Disorder, and Somatic Disorders (including Somatization Disorder and Somatoform Disorder).
2. The psychiatrists and psychologists were asked to rate each item as not consistent, somewhat consistent, or very consistent with each diagnostic category. Raters were given the *DSM* criteria for guidance, but one-to-one matching of *DSM* criteria to ASR items was not required to justify rating ASR items as very consistent with a *DSM* category. Some ASR items could thus be judged as very consistent with the raters' concepts of

particular *DSM* categories even if the *DSM* lacked precise counterparts of the items. As stated earlier, the raters were 21 psychiatrists and psychologists from 10 different cultures. The raters had a mean of 17.8 years experience since receiving their first doctorate or equivalent degree. Eight had both M.D. and Ph.D. degrees. All raters had published on adult psychopathology (Achenbach & Rescorla, 2003).

3. Items that were rated as very consistent with a particular *DSM* category by at least 13 of the 21 raters were deemed to be sufficiently consistent with that category to be included in the *DSM*-oriented scale for that category.

4. The items that were listed as very consistent with the categories by at least 62% of the raters were grouped into the following *DSM*-oriented scales: 1) Depressive problems; 2) Anxiety problems; 3) Somatic problems; 4) Avoidant personality problems; 5) Attention Deficit/Hyperactivity problems; and 6) Antisocial personality problems.

The *DSM*-oriented scales were normed on the same national sample as the empirically based scales; thus, the ASR profile of *DSM*-oriented scales compares a client's scores with ASR ratings obtained in the national sample. It is important to understand that, for the following reasons, a particular score on a *DSM* scale is not directly equivalent to a *DSM* diagnosis.

1. The items on the *DSM* scales do not correspond precisely to criteria for *DSM* diagnosis.

2. The items scored reflect the respondent's judgment of whether the client has manifested particular problems during the period covered by the ratings. However, the scores do not include criteria for impairment, age of onset, or duration of problems, which are included in the criteria for some *DSM* diagnosis.

3. The 0-1-2 item scores are summed to obtain a total score for each scale. By contrast, each *DSM* criteria attribute must be judged as present versus absent, and the diagnoses are based on yes versus no judgment of whether enough *DSM* criteria characteristics are present.

4. The profile indicates how high a client is on each *DSM* scale as compared to a national sample of adults of roughly the same age and gender who were rated by themselves or other informants. By contrast, the criteria for official yes versus no *DSM* diagnosis are the same for people of all ages and genders.

Because the *DSM*-oriented scales are quantified, they can be used to assess the severity of problems. This result enables one to compare the *DSM*-oriented scale scores obtained prior to and following interventions (Achenbach & Rescorla, 2003).

Reliability

The optimal method for obtaining a truly representative sample of a population is via probability sampling. In probability sampling, all individuals in the target population have similar probabilities of being selected. A multistage national probability sample was obtained from Temple University's Institute for Survey Research (ISR), and certain steps were carried out. Data from this national sample were used to construct norms for the adaptive scales, the substance use scales, and the critical items scales. The steps included (Achenbach & Rescorla, 2003):

1. ISR selected and trained interviewers to work in 100 Primary Sampling Units (PSU's), which were selected to be representative of the United States.
2. The PSU interviewers were assigned certain listing areas of 150 households to determine the age and gender of residents who were eligible for the survey.

3. The adult candidates had to speak English and have no serious physical disabilities or mental retardation.
4. Stratified random procedures were used to select the participants for overall age distribution, with similar proportions in each gender at each age.
5. After the respondent took the assessment, in which the respondent would read each answer aloud and the interviewer would write answer on second copy, the respondent was asked to describe a stressful situation that had occurred in last 12 months. The respondent also indicated if any mental health or substance abuse services were received during the last 12 months.
6. From the 2,146 eligible 18-59 year-olds selected from the initial household screening, the assessments were completed by 94.1%.
7. The final national probability sample included respondents from 40 states. From this sample, norms were constructed from the data for people who had not received mental health or substance abuse services in the proceeding 12 months. The sample of non-referred people provided the basis for the norms with which the scale scores of individuals 18-59 year-olds could be compared to identify scores that are in the normal, borderline, or clinical range. To take into account gender differences, separate norms were constructed.

Reliability refers to agreement between repeated assessments of characteristics when the characteristics themselves are expected to remain constant. Another property of scale scores is their internal consistency. This principle refers to the degree to which the items of a scale are correlated with each other. A further aspect of scale scores is their stability when the same informants complete forms over intervals long enough for

behavior to change. Data on the stability of scale scores for substantial samples of adults can provide reference points for the typical level of those scales' stability (Achenbach & Rescorla, 2003).

To assess reliability in both the rank ordering and magnitude of scale scores, both test-retest Pearson correlations (r) and t -tests of differences between ASR ratings on two occasions were preformed. Reliability was very high, with all test-retest r s being significant at $p < .01$ and most being in the .80's and .90's. The mean r for the empirically based problem scales was .88 on the ASR, whereas the r 's for total problems were .94. For the *DSM*-orientated scales, the mean r was .83.

There were significant ($p < .05$) declines in scores on the scales that are marked with subscript d in Table A. Four of the significant changes in each column would be expected by chance, based on the number of analyses that were done using a $p < .05$ protection level Super script e indicated the differences that were most likely to be significant by chance, because they yielded the smallest t values.

Identified as the test-retest attenuation effect, the tendency for individuals to report fewer problems at a second assessment is typically discovered in rating forms and questionnaires. Note that this effect is not from regression toward the mean, because it is discovered in samples in which initial scores are not very high. Seventeen of the 32 test-retest comparisons showed significant changes in mean scores.

The four marked with subscript e would be expected by chance. None of the adaptive functioning or substance abuse scales showed significant changes in mean scores over the one-week interval.

As mentioned earlier, the syndrome scales were derived from factor analyses of the correlations among the ASR items. The composition of the scales is, therefore, based on internal consistencies among certain subsets of items. The degree of internal consistence of the scales is in the form of Cronbach's alpha for each scale. Alpha represents the mean of the correlations between all sets of half the items comprising a scale. Alpha tends to be directly related to the length of the scale, because half the items of a short scale provide a less stable measure than half the items of a long scale.

The alphas for the adaptive functioning scales were moderately high, ranging from .60 to .78, except the Education scale, the alpha of which was .51. These alphas are reasonable for scales that have only a few items.

For the empirically based problem scales, the alphas ranged from .51-.97. The only alpha less than .70 was on the Thought problems syndrome, which is comprised of low-prevalence items. For the *DSM*-oriented scales, the alphas ranged from .68-.88. The only alpha <.70 was on the Anxiety Problem scale.

Validity

Validity refers to the accuracy with which instruments assess what they are supposed to assess. The ASR problem items are a product of a long process of development, testing, and refinement on the basis of research and practical experience, as well as by findings that most of the items retained for scoring on scales discriminate significantly between demographically similar referred and nonreferred adults (Achenbach & Rescorla, 2003).

The adaptive functioning items were hypothesized to reflect aspects of functioning that are important for successful adaptation in various areas. The ASR

adaptive functioning items pertaining to friends and family are relevant to nearly all adults. The items pertaining to spouse/partner, job, and education are completed for adults for whom they have been relevant in the preceding six months.

To test the ability of each scale to discriminate between referred and nonreferred adults, samples were matched for gender and were similar in age distributions. The referred adults came from 17 mental health and substance abuse treatment settings. The nonreferred adults came from the participants from the 1999 National Survey who reported not receiving mental health or substance abuse treatment in the last 12 months. The differences in age and ethnicity were controlled by treating them as covariates in ANCOVAs as an independent variable in multiple regression analyses.

To test the associations of referral status and demographic variables with scale scores, the structural equation modeling (SEM) approach was used. All independent variables were entered simultaneously to test the predictive power of each independent variable with the other partialled out. SEM was also used to regress the raw scores of each problem scale. These analyses were done for the three substance use scales, mean substance use, Critical Items, the eight syndromes, Internalizing, Externalizing, Total Problems, the six *DSM*-oriented scales, and two AD/H subscales.

To correct for shrinkage, a "jackknife" procedure was implemented. The discriminant function for each sample was computed multiple times with a different person held out of the sample each time. Each discriminant function was then cross-validated by testing the accuracy of its prediction for each of the "hold-out" people. Finally the percentage of correct predictions was computed across all the hold-out individuals.

Another approach to discriminate between referred versus nonreferred people is to use weighted combinations of scores. A stepwise discriminant analysis was used for the ASR in which the criterion groups were the demographically similar samples of referred versus nonreferred people. The discriminant analysis achieved the best cross-validated accuracy of 87% of participants correctly classified when selecting from all the problem items on the ASR.

Procedures

To determine clinical change among adult clients of counselors who and were not child-centered play therapists, a quantitative study using archival data evaluating assessment scores was completed. Specifically, the investigation consisted of two steps:

1. Gather data by collecting information from adult clients of Master's practicum students. All clients completed at least 10 counseling sessions. Clients answered questions from a pre- and post-assessment measure, determining symptomology and degrees of distress.
2. Address the major questions of the study: (a) Do adult clients of counselors educated in child-centered play therapy report significantly greater positive behavioral change than adult clients of counselors not educated in child-centered play therapy as shown by significant statistical outcomes on three major scales of the ASR, and if so, to what degree? And (b), will play therapists show more clinical effectiveness in improving particular areas of client distress on the subscales (i.e. depression/anxiety, relationship issues)?

Due to the fact that this study employed the use of archival data, clinic procedures to collect data were utilized. Community clients followed clinical admission procedures

consisting of completing of an intake form, an assessment by intake counselor to briefly determine presenting issue(s) and immediate symptomology of client; a background information form; a right to privacy and informed consent approval and signature; and the ASR pre-treatment adult symptomology assessment. The college extra credit students completed all the above, aside from intake assessment. After clients were assigned a counselor, clients were scheduled for sessions. The clients were required to read and sign a professional disclosure statement from their counselors and undergo, at minimum, 10 sessions of counseling. After treatment, clients were required to complete the ASR, and counselors evaluated clients' current psychological status in client treatment summary, determining if terminating therapy or continuing counseling was most appropriate.

Once again, the ASR naturally divides itself into five distinct headings: Adaptive Functioning, Substance Abuse, Internalizing/Externalizing, Total Problems, and *DSM*. Each section underwent pre-posttest measurement, and a 2X2 repeated measure ANOVA was used as the statistical measure.

As stated earlier, the number of clients/respondents were 30 individuals in each group. The dependent variable in this study is the data that was collected from each respondent's assessment. The independent variable in this study was whether the counselor was or was not a play therapist. The respondents' before treatment scores were logged and measured, followed by a measurement of the outcome assessment scores at conclusion of treatment. Respondents who clearly breach the "inventory premise" of the assessments with disorders or symptoms such as delirium, mental retardation, or floridly psychoticism were not used in this study. The ASR contains borderline and clinical thresholds within which each client's score had to fall for the client to qualify as a

participant in the study. Scores fall within a *t*-score range of 20-55 on the Adaptive Functioning Scale, with borderline scores = 31-35 and clinical scores < 31; 50-100 on the Total Problem Scale with borderline scores = 60-63, and clinical scores > 63; 50-100 on the Internalizing/Externalizing Scale between 50-100 with borderlines scores = 60-63, and clinical scores > 63; 50-100 on the DSM Scale with borderline scores = 65-69 and clinical scores > 69; and Substance Use scores between 50-100 with borderline scores between 65-69 with clinical scores > 69. Therefore all client participants in this study must have operated in the measurable range of the ASR scales.

Outside of these ranges are considered poor candidates for self-inventories. Persons who would be motivated to distort answers either by purposely minimizing or exaggerating distress were not considered. Once again, this research is determining the difference in ASR post-treatment means between clients of counselors who are and are not play therapists. For a psychological assessment to be optimally useful as a treatment outcome measure, it should document the post-treatment condition of a client in current terminology that establishes post-intervention status in a clinically meaningful manner.

It is believed to be insufficient to indicate a respondent's unelaborated post-treatment score or to report a reduction or change in score of a particular magnitude without the meaning of what a particular score represents (Derogatis, 1994). Therefore, the ASR possesses an actuarial database, or norm, for the population studied. The norm describes the distribution of scores in the particular population of interest, in this case, university students and community clients.

Table 1

Summary of Borderline and Clinical Ranges on ASR Profiles

Adaptive Functioning

| |
|----------------------|
| Borderline T = 31-35 |
| Clinical T < 31 |

Total Problems Scores

| |
|----------------------|
| Borderline T = 60-63 |
| Clinical T > 63 |

Internalizing

| |
|----------------------|
| Borderline T = 60-63 |
| Clinical T > 63 |

Externalizing

| |
|----------------------|
| Borderline T = 60-63 |
| Clinical T > 63 |

**Substance Use and
Critical Items Scales**

| |
|----------------------|
| Borderline T = 65-69 |
| Clinical T > 69 |

**Syndrome and DSM-Oriented
Scales**

| |
|----------------------|
| Borderline T = 65-69 |
| Clinical T > 69 |

(Achenbach & Rescorla, 2003)

All 60 adult clients participated in counseling sessions within the course of one academic semester, averaging 10 counseling sessions. Only one client per counselor was included in this study. An important question arising from clinicians and investigators who are involved in outcome measure is, "How frequently should outcome assessments be conducted?" There is no definitive answer to this question. Assessment frequency and pre-posttest measures should be determined by what is relevant for judicious clinical or investigative decision making (Derogatis, 1994).

Due to the nature of this study and circumstances surrounding it, the researcher determined treatment over the course of one semester was sufficient to determine if the specialized education child-centered play therapists possess would translate into a significant difference in reported behavioral change of their adult clients compared to that of the clients seen by the non-play therapists.

By design, all counseling sessions were conducted at a counseling program's clinic on a university campus. All sessions were individual treatment sessions. All counselors participated in supervision each week, consisting of individual or triadic supervision with a professor or doctoral student, and all participants engaged in weekly group supervision. Specifically, a semester practicum consisted of each therapist counseling at least three different individuals, often more than three, to acquire the required 30 client contact hours needed. Counselors also received brief feedback forms each week from their clients. Each counselor wrote and presented a client conceptualization to the practicum class, which usually consisted of 7-12 Master's students. See attached Practicum Syllabus for further requirements.

Concerning administering the assessment, a minimal amount of instruction is required to assure measurement validity. In any assessment context, the clinician's attitude concerning value of the assessment will potentially affect the quality of the respondents' answers. The ASR assessment was introduced to respondents in a positive and informed manner that communicated importance of the psychological assessment and relevance of resulting data to their health status and potential treatment. Respondents had easy accessibility to clinician or staff to deal with any questions that might have arisen pertaining to assessment administration or assessment concerns.

Analysis

The analysis was conducted using a 2X2 repeated measure ANOVA to calculate possible statistical significance among three of the ASR's major scales: Internalizing, Externalizing, and Total Problems. These three scales were chosen because they best represent total respondent symptomology for this particular study. All individual items have a ranking of: 0 = Not True, 1 = Somewhat or Sometimes True, and 2 = Very True or Often True.

The Internalizing Scale, which comprises a broad grouping of problems that are mainly within the self, measures levels of: (1) Somatic complaints, consisting of issues such as dizziness, heart pounding, vision problems, skin problems, and nausea. (2) The Anxious/depressed subscale measures items such as worthlessness, sad, worries, confused, and nervous, and (3), the Withdrawn subscale items rate issues such as not liked, secretive, enjoys little, and no friends (Achenbach & Rescorla, 2003).

The Externalizing Scale, measuring conflicts with others and social mores, also covers a broad grouping of problems. Categories include: (1) Aggressive behavior, rating

items such as argues, blames, screams, stubborn, and impatient, and (2) Rule-breaking behavior, with items including lies, cheats, can not keep job, lacks guilt, and irresponsible; and (3) Intrusive, with items such as brags, talks too much, loud, and demands attention (Achenbach & Rescorla, 2003).

The Total Problems score is the sum of the 1 and 2 scores on all the problem items of the ASR. If a respondent scores every problem item 0, the Total Problems score would be 0. If a respondent scores every problem a 2, the Total Problem score would be 240. It is important to note the ASR has 11 socially desirable items that are not included in the Total Problems score (Achenbach & Rescorla, 2003).

Two subscales, (1) Relationship and (2) Anxiety/Depression, were chosen for this study based on the fact these two areas of concern appeared more than all other issues of respondents' symptomology. Seventeen play therapists' clients reported pre-assessment issues revolving around relationship problems, whereas 15 clients of non-play therapists reported issues. Anxiety and depression issues were reported by 14 play therapists' clients, whereas 12 non-play therapists' clients reported problems in this area. Obviously, not all clients in the study reported pre-test concerns on these scales, but enough did to warrant measurement. These two sub-scales were also measured using 2X2 repeated measure ANOVA. The Relationship scale measured areas of issues within friendships, spouse, and family matters, and rated items in areas such as how many close friends, how well they get along, satisfied, sharing, brothers, sisters, oldest, and other. The Anxiety/Depression scale consisted of items such as fears doing bad, lacks self-confidence, sad, nervous, cries, and unloved (Achenbach & Rescorla, 2003).

Each of the respondent's pre- and post-test means were calculated and difference in means assessed. The adult clients chosen for the study all shared relatively similar pre-test scores, staying within the thresholds. The pre-test means of all assessments for each group were compared and averaged, confirming an obvious symptomology similarity. Varying degrees of client symptomology were controlled by assigning an equal number of clients to each group displaying equal levels of distress. After treatment, all post-test means of clients were scored and compared between play therapists and non-play therapists.

CHAPTER 3

RESULTS AND DISCUSSION

This chapter provides results on stated assumptions, as well as information related to results ascertained through the Adult Self Report (ASR) assessment. In the discussion portion of this chapter, I describe the quantitative aspects of the research that I used to measure statistical and practical significance in the findings. I was attempting to test the hypothesis that adult clients of child-centered play therapists would report significantly greater improvement from counseling than adult clients treated by non-play therapists on pre and post-test group comparisons.

For the statistical tests on differences between the two groups ($N = 60$; 30 in each group) in the two measurement occasions, 2 x 2 repeated measurement ANOVAs were conducted on the five factor scores. A partial Eta squared (η^2) was used to determine effect size and the strength of the findings. The partial Eta squared is an estimate of the amount of variability in the dependent variables explained, or accounted for by individuals defining the independent variable (Thompson, 2004). If statistical significance is found, Eta squared helps determine how much influence the dependent variable has on the outcome. In this case, for a 2x2 split-plot design, there are three independent variables: group, measurement occasion, and the interaction between group and measurement.

Eta square means how much of the variance on the dependent variable could be explained by the independent variables. The main interest for an experimental study is the main effect of group, called between-subject effect. In the ANOVA tables, it is the first row.

In the field of educational research, an effect size of .01 is considered small, .05 is medium, and .08 is large (Cohen, 1988).

The five factor scores consist of five scales. The three primary scales: Internalizing, Externalizing, and Total Problems were measured; and two subscales, Relationship Scale and Anxiety/Depression Scale, were measured based on the fact that these two areas of client symptomology were reported in the pre-assessments more than any other areas of concern.. In all of the cases, the dependent variables were normally distributed and the assumptions of sphericity and the equality of covariances were met.

Three major scales -- Internalizing, Externalizing, and Total Problems -- were compared to determine any reported significant differences between the play therapists' and non-play therapists' clients after 10 counseling sessions. Also, two subscales -- Relationship Issues and Anxiety/Depression -- were also compared between the two groups.

Table 2

Descriptive Statistics on the Adult Self-Report;

Differences Between Pre and Post

| | <i>N</i> | | <i>M</i> | | <i>SD</i> | |
|-----------------------|-------------|-----------------|-------------|-----------------|-------------|-----------------|
| | <i>Play</i> | <i>Non-play</i> | <i>Play</i> | <i>Non-play</i> | <i>Play</i> | <i>Non-play</i> |
| Pre-test | | | | | | |
| Internalizing problem | 30 | 30 | 54.80 | 54.63 | 11.39 | 10.06 |
| Externalizing problem | 30 | 30 | 51.93 | 50.57 | 7.62 | 9.06 |
| Total problem | 30 | 30 | 52.33 | 51.67 | 8.83 | 9.12 |
| Relationship | 17 | 15 | 42.95 | 44.65 | 4.58 | 6.47 |
| Anxiety/depression | 14 | 12 | 66.08 | 60.86 | 7.04 | 9.17 |
| Post-test | | | | | | |
| Internalizing problem | 30 | 30 | 50.87 | 52.23 | 9.69 | 10.71 |
| Externalizing problem | 30 | 30 | 48.53 | 48.77 | 7.43 | 8.56 |
| Total problem | 30 | 30 | 48.77 | 48.47 | 7.42 | 9.04 |
| Relationship | 17 | 15 | 46.40 | 45.94 | 6.99 | 5.56 |
| Anxiety/depression | 14 | 12 | 58.92 | 57.43 | 5.40 | 7.00 |

Internalizing Scale

After 10 sessions, a statistically significant reduction in symptomology on the Internalizing scale was not found between the two groups of clients. For between group difference (combining the two tests), $F(1, 58) = .054, p = .817$. For within-subject difference between the pre-test and post-test (combining two groups), $F(1,58) = 15.100, p = .0003$.

Table 3

Repeated Measure ANOVA Summary Table for the Internal Scale Score

| Source | <i>SS</i> | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2 |
|-----------------------|-----------|-----------|-----------|----------|----------|----------|
| Group | 10.800 | 1 | 10.800 | .054 | .817 | .001 |
| Error between subject | 11589.067 | 58 | 199.811 | | | |
| Measurement | 300.833 | 1 | 300.833 | 15.100 | .0003 | .207 |
| Group x Measurement | 17.633 | 1 | 17.633 | .885 | .351 | .015 |
| Error within subject | 1155.533 | 58 | 19.923 | | | |

For the interaction effect, there is no difference: $F(1,58) = .885, p = .351$. The research assumption was not met: Play therapists' adult clients were not significantly less symptomatic than non-play therapists' clients. The play therapists' clients went from a pre-test mean score of 54.8, down to a post-test mean score of 50.87, equaling a reduction of symptomology by 3.93, and the non-play therapists' clients went from a pre-test mean score of 54.63 to a post-test mean score of 52.23, equaling a reduction of 2.4. There was no significant difference on the pre-test between the two groups. The assumption was the

play-therapists' clients would show significantly lower post-test scores, indicating client improvement, than the non-play therapists' clients. This outcome did not occur.

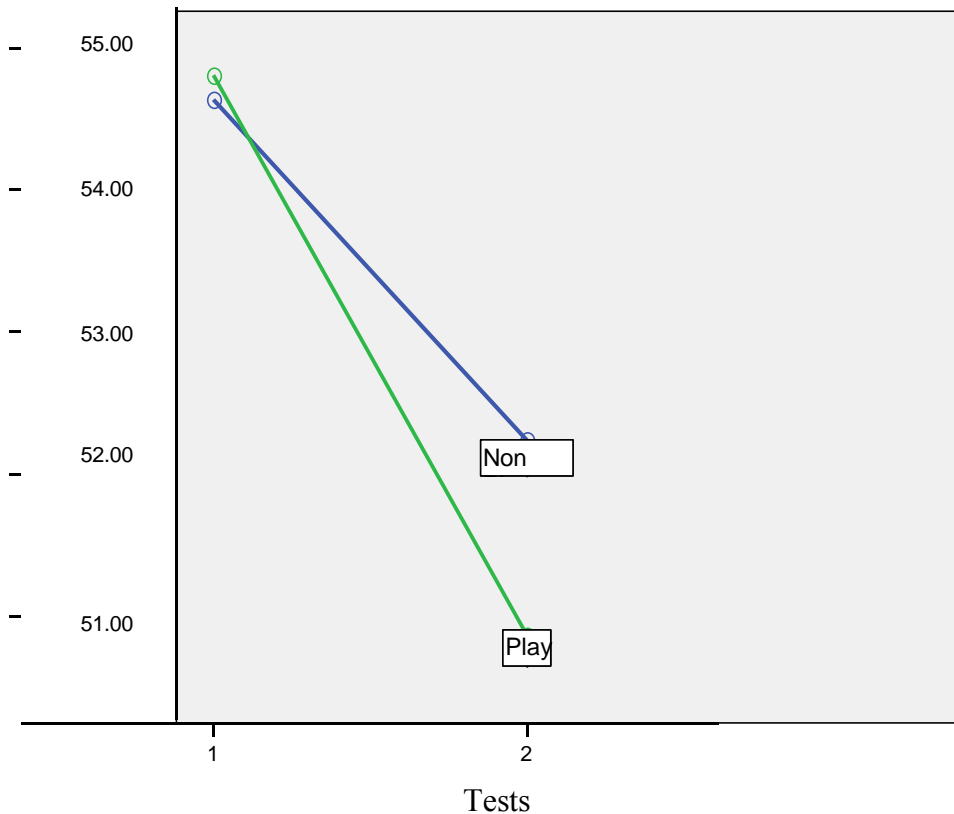


Figure 1. Estimated marginal means of Internal scale.

Externalizing Scale

After 10 sessions, a statistically significant reduction in symptomology on the Externalizing scale was not found between the two groups of clients. For between group difference (combining the two tests), $F(1, 58) = .084, p = .774$. For within-subject difference between the pre-test and post-test (combining two groups), $F(1, 58) = 10.597, p = .002$.

Table 4

Repeated Measure ANOVA Summary Table for the Externalizing Scale Score

| Source | <i>SS</i> | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2 |
|-----------------------|-----------|-----------|-----------|----------|----------|----------|
| Group | 9.633 | 1 | 9.633 | .084 | .774 | .001 |
| Error between subject | 6684.067 | 58 | 115.243 | | | |
| Measurement | 202.800 | 1 | 202.800 | 10.597 | .002 | .154 |
| Group x Measurement | 19.200 | 1 | 19.200 | 1.003 | .321 | .017 |
| Error within subject | 1110.000 | 58 | 19.138 | | | |

For the interaction effect, there was no difference: $F(1,58) = 1.003, p = .321$. The research assumption was not met: Play therapists' adult clients were not significantly less symptomatic than non-play therapists' clients. The play therapists' clients went from a pre-test mean score of 51.93, down to a post-test mean score of 48.53, equaling a reduction of symptomology by 3.4, and the non-play therapists' clients went from a pre-test mean score of 50.57 down to a post-test mean score of 48.77, equaling a reduction of 1.8. There was no statistically significant difference on the pre-test between the two groups. The assumption was that play-therapists' clients would show significantly lower scores, indicating greater client improvement, than the non-play therapists' clients on the post-test. This outcome did not occur.

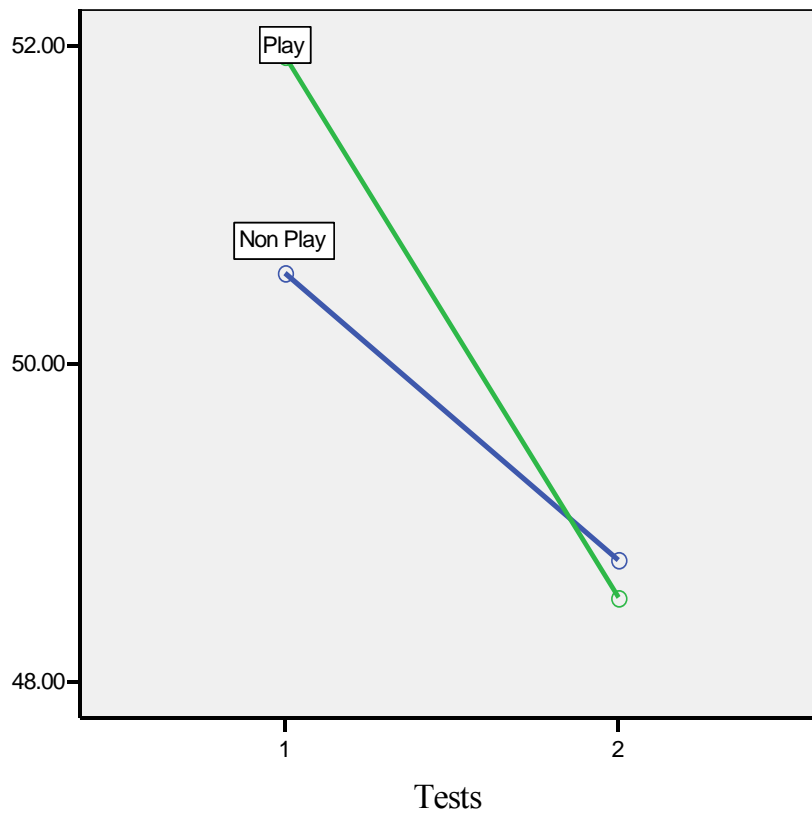


Figure 2. Estimated marginal means of External scale.

Total Problem Scale

For between group difference (combining the two tests), $F(1, 58) = .058, p = .811$.

For within-subject difference between the pre-test and post-test (combining two groups),

$F(1, 58) = 12.542, p = .001$.

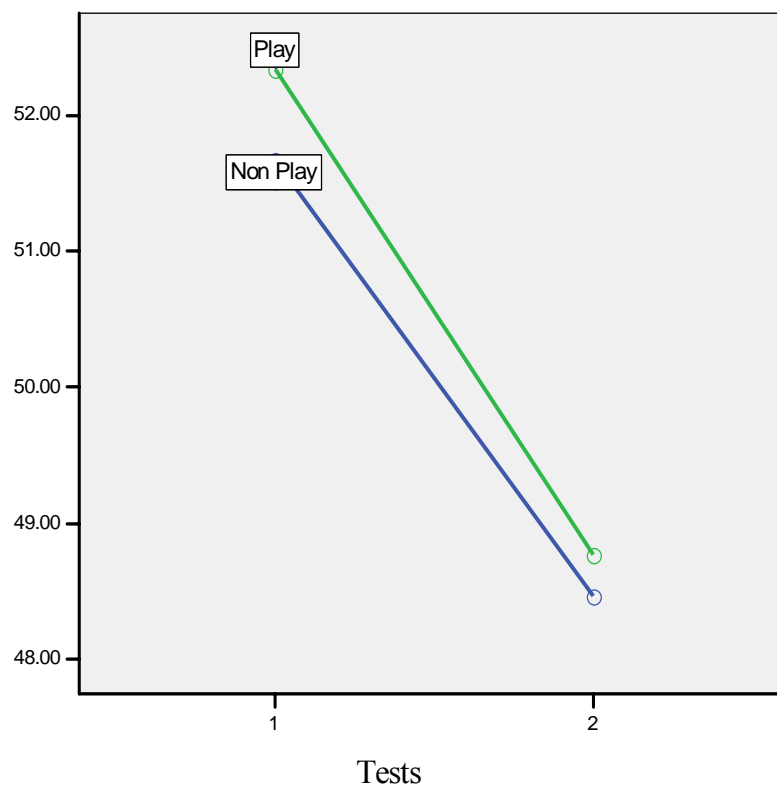
For the interaction effect, there was no difference: $F(1, 58) = .037, p = .848$.

The hypothesis was not supported that play therapists' clients would show a statistically significantly greater decrease in externalizing symptoms than non-play therapists' clients.

Table 5

Repeated Measure ANOVA Summary Table for the Total Problem Score

| Source | <i>SS</i> | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2 |
|-----------------------|-----------|-----------|-----------|----------|----------|----------|
| Group | 7.008 | 1 | 7.008 | .058 | .811 | .001 |
| Error between subject | 7056.083 | 58 | 121.657 | | | |
| Measurement | 343.408 | 1 | 343.408 | 12.542 | .001 | .178 |
| Group x Measurement | 1.008 | 1 | 1.008 | .037 | .848 | .001 |
| Error within subject | 1588.083 | 58 | 27.381 | | | |

*Figure 3.* Estimated marginal means for Total Problems scale.

The play therapists' clients went from a pre-test mean score of 52.33, down to a post-test mean score of 48.77, equaling a reduction of symptomology by 3.8, and the non-

play therapists' clients went from a pre-test mean score of 51.67 down to a post-test mean score of 48.47, equaling a reduction of 3.2. There was no statistically significant difference on the pre-test between the two groups.

The assumption was play-therapists' clients would show significantly lower scores, indicating client improvement, than the non-play therapists' clients on the post-test. This outcome did not occur. There was no significant difference on the post-test between the two groups.

Relationship Scale

For between group difference (combining the two tests), $F(1, 30) = .104, p = .749$. For within-subject difference between the pre-test and post-test (combing two groups), $F(1,30) = 6.803, p = .014$. For the interaction effect, there was no difference: $F(1,30) = 1.402, p = .246$.

Table 6

Repeated Measure ANOVA Summary Table for the Relationship Score

| Source | <i>SS</i> | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2 |
|-----------------------|-----------|-----------|-----------|----------|----------|----------|
| Group | 6.076 | 1 | 6.076 | .104 | .749 | .003 |
| Error between subject | 1746.567 | 30 | 58.219 | | | |
| Measurement | 89.549 | 1 | 89.549 | 6.803 | .014 | .185 |
| Group x Measurement | 18.461 | 1 | 18.461 | 1.402 | .246 | .045 |
| Error within subject | 394..913 | 30 | 13.164 | | | |

The research assumption was not met: Play therapists' adult clients were not significantly less symptomatic than non-play therapists' clients. The play therapists'

clients went from a pre-test mean score of 42.95, up to a post-test mean score of 46.40, indicating an improvement of 3.45, and the non-play therapists' clients went from a pre-test mean score of 44.65 down to a post-test mean score of 45.94, indicating an improvement by 1.29. There was no statistically significant difference on the pre-test between the two groups.

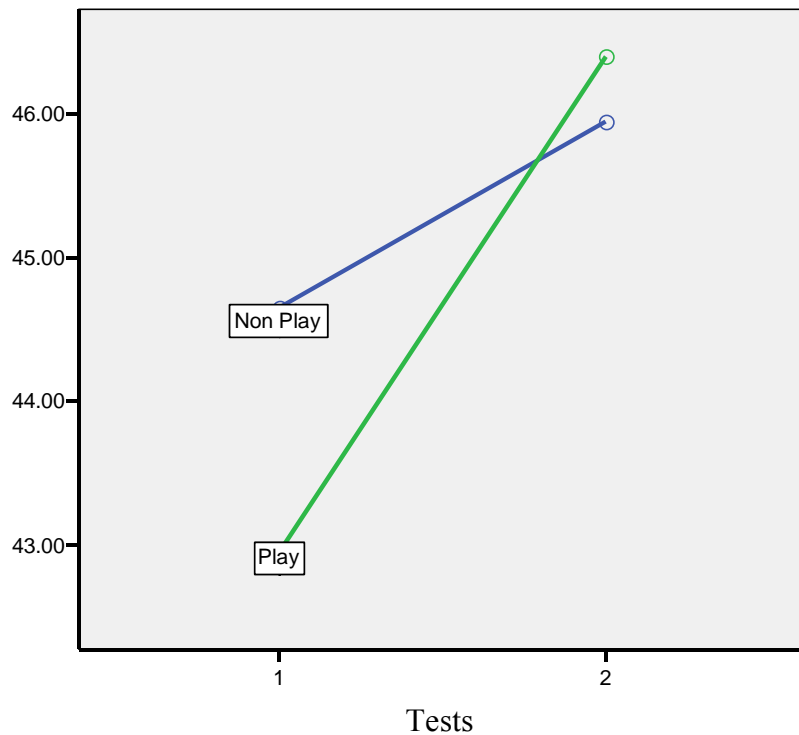


Figure 4. Estimated marginal means of Relationship scale.

The assumption was the play-therapists' clients would show significantly higher scores, indicating greater client improvement, than the non-play therapists' clients on the post-test. This outcome did not occur. There was no significant difference on the post-test between the two groups.

Anxiety/Depression Scale

For between group difference (combining the two tests), $F(1, 24) = 1.684, p = .207$. For within-subject difference between the pre-test and post-test (combining two groups), $F(1,24) = 16.690, p = .0004$.

For the interaction effect, there was no difference: $F(1,24) = 2.077, p = .162$. The research assumption was not met: Play therapists' adult clients were not significantly less symptomatic than non-play therapists' clients. The play therapists' clients went from a pre-test mean score of 66.08, down to a post-test mean score of 58.92, showing a decrease in symptomology by 7.16, and the non-play therapists' clients went from a pre-test mean score of 60.86 down to a post-test mean score of 57.43, showing a decrease in symptomology by 3.43. There was no significant difference on the pre-test between the two groups.

Table 7

Repeated Measure ANOVA Summary Table for Anxiety/Depression

| Source | <i>SS</i> | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2 |
|-----------------------|-----------|-----------|-----------|----------|----------|----------|
| Group | 145.648 | 1 | 145.648 | 1.684 | .207 | .066 |
| Error between subject | 2075.429 | 24 | 86.476 | | | |
| Measurement | 362.683 | 1 | 362.683 | 16.690 | .00004 | .410 |
| Group x Measurement | 45.154 | 1 | 45.145 | 2.077 | .162 | .080 |
| Error within subject | 521.548 | 24 | 21.731 | | | |

The assumption was the play-therapists' clients would show significantly lower scores, indicating client improvement, than the non-play therapists' clients on the post-test. This did not occur. There was no significant difference on the pre-test between the two groups.

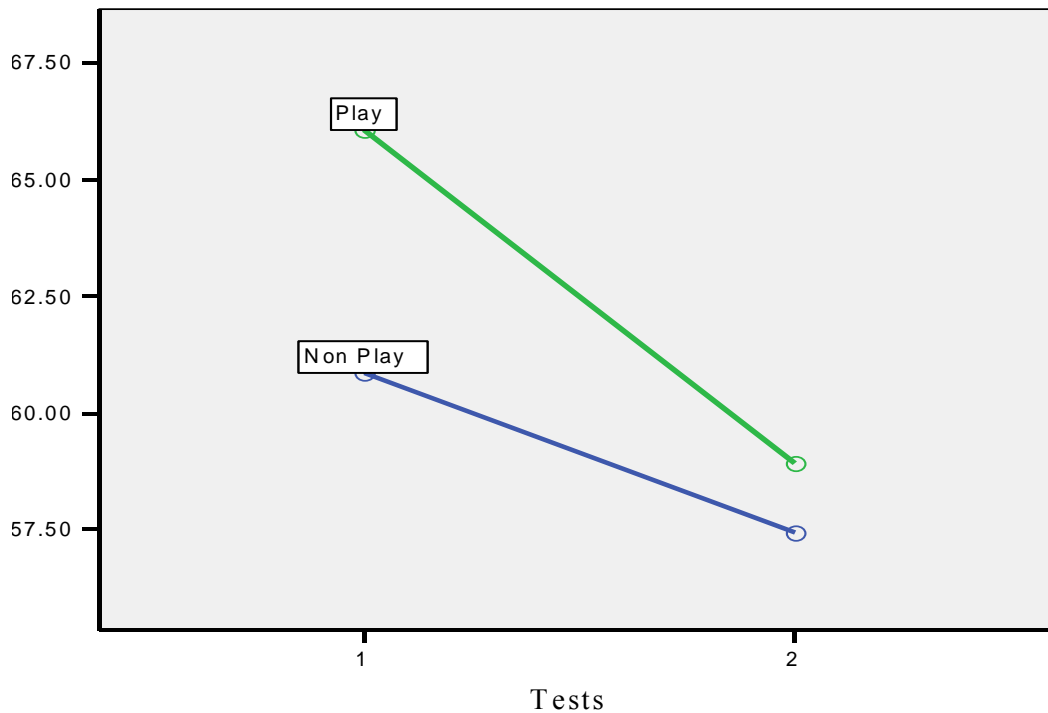


Figure 5. Estimated marginal means of Anxiety/Depression scale.

As shown on the graphs, the play therapists' clients did show greater improvement on all five scales, although the improvement was not statistically significant. For all of the six continuous variables (age plus the five factor scores), the equal variances assumption was met in all of the cases. Results show there were no initial differences. For detecting the initial difference to check the comparable baseline for gender, there is also no difference. The ratio of gender distribution pattern in the two groups is similar.

Table 8

Skewness and Kurtosis and the Z scores

| Variables | <i>n</i> | Skewness | Kurtosis | Z-score for skewness | Z-score for Kurtosis |
|--------------------|----------|----------|----------|-------------------------|-------------------------|
| Pre-test | | | | | |
| Internal problem | 60 | .23 | -.45 | .72 | -.71 |
| External problem | 60 | -.12 | -.63 | -.38 | -1.00 |
| Total problem | 60 | .16 | -.51 | .50 | -.81 |
| Relationship | 32 | .44 | -.09 | 1.02 | -.11 |
| Anxiety/depression | 26 | -.28 | -1.10 | -.59 | -1.15 |
| Post-test | | | | | |
| Internal problem | 60 | .12 | -.68 | .38 | -1.08 |
| External problem | 60 | .10 | -.54 | .33 | -.86 |
| Total problem | 60 | -.21 | .31 | -.67 | .50 |
| Relationship | 32 | .02 | -.13 | .04 | -.15 |
| Anxiety/depression | 26 | .23 | -1.08 | .48 | -1.12 |

There are four major assumptions for a repeated measure ANOVA: (a) random sampling from the population, (b) independence of participants, (c) the normal distribution of the dependent variables, and (d) homogeneity of treatment-difference variances or sphericity (Maxwell & Delaney, 2004). Although there was no way to justify this sample was random from the population -- as in many other studies using convenient samples, the effect of the violation to the first assumption on the Type I error rate was minimal (Glass, Peckham, & Sanders, 1972). As every participant associated with each of

the 60 counselors was not related, the second assumption was met. Several approaches are available to examine normality of data. One way is to check the graphics such as a histogram with the normal curve or the Q-Q plot generated from statistical packages (Maxwell & Delaney, 2004). The approach used in this study was to assess normality using a rule of thumb recommended by Hair, Black, Babib, Anderson, and Tatham (2006), based on the skewness and kurtosis values and the sample size, as in the formulae

$$\text{of } z_{skewness} = \frac{skewness}{\sqrt{\frac{6}{N}}} \text{ and } z_{kurtosis} = \frac{kurtosis}{\sqrt{\frac{24}{N}}} \text{ where } N \text{ is the sample size. If the calculated}$$

$z_{skewness}$ or $z_{kurtosis}$ is in the range of ± 1.96 , the data are normally distributed at the .05 level. Table 1 shows that all of the five dependent variables in both the pre-test and post-test are normally distributed. The last sphericity assumption is always met for the two-level pre-and-post test within-subject design (Hair et al., 2006). In conclusion, all four assumptions for repeated measure ANOVAs were primarily met in the case of all five dependent variables.

As shown in Table 1, all 60 respondents were measured on the Internalizing, Externalizing, and Total Problems scales. Although the play therapists' clients post-test mean on the Internalizing scale had a change of 3.93, and the non-play therapists' clients post-test mean changed by only 2.4, the post-test means were similar, showing a small difference of 1.36, with post standard deviations of 9.69 and 10.71, respectively.

On the Externalizing scale, the play therapists' clients pre and post-test means had a change of 3.4, while the non-play therapists clients had a mean difference of 1.8. Yet, the two groups post-test means were very similar at 48.5 and 48.7, with post standard deviations of 7.43 and 8.56, respectively.

For the Total Problems scale, the play therapists' clients reported a difference of 3.8 between the pre and post-test mean scores, with a post standard deviation of 7.42, while the non-play therapists' clients who reported borderline or clinical symptomology measured a mean difference of 3.2 and a post standard deviation of 9.04; yet, the post-test mean for the play therapists' group was 48.77, and the post-test mean of the non-play therapists' groups was 48.47, showing a strikingly similar result.

Concerning the Relationship scale, the play therapists' 17 clients who indicated borderline or clinical symptomology reported a pre-test mean of 42.95, and a post-test mean of 46.4, a difference of 3.45 with a post standard deviation of 6.99. The non-play therapists' group of 15 clients who reported borderline or clinical symptomology measured a pre-test mean of 44.6, and a post-test mean of 45.9 showing a difference of only 1.3 with a standard deviation of 5.56. Yet, the post-test means of the groups only differed by 0.5.

For the Anxiety/Depression scale, the pre-test mean of the play-therapists' 14 clients who reported borderline or clinical symptomology measured a mean score of 66.08, and the post-test mean was 58.92, a difference of 7.16 with a post-standard deviation of 5.4. The non-play therapists' 12 clients who reported borderline or clinical symptomology measured a pre-test mean of 60.86 and the post-test was 57.43, a difference of 3.43 with a post-standard deviation of 7.00. Yet, the post-test means of the two groups only differed by 1.5.

Discussion and Recommendations

The conclusion of much research is that the strength of the therapeutic relationship established between client and counselor is an essential factor in counseling outcome, possibly the most important factor (Asay & Lambert, 1999). The relationship accounts for a substantial degree of client improvement (Lambert & Cattani-Thompson, 1996). Child-centered play therapists spend a great deal of time and energy sharpening and honing relationship building skills and employ these counseling dimensions extensively with child clients. Child-centered play therapists also are educated to heighten their awareness of non-verbals, body language, facial expressions, and theme identification. It thus seemed warranted to investigate the possibility that child-centered play therapists, when using their specialized counseling skills with adult clients, would prove more therapeutically effective with adult clients than non-play therapists, as shown by client self-reporter treatment outcomes.

Although post-treatment outcomes from both groups resulted in very similar and improved scores, the researcher found child-centered play therapists were slightly more effective on all five scales at reducing client symptomology and improving behavioral change within the group, regardless of age, gender, college student client, or community client. That is to say, the differences were greater, although not statistically significant, between the pre and post-treatment means of the play therapists' clients than the pre and post-treatment means of the non-play therapists' clients.

Although results did not yield statistical or practical significance, an argument for discovered clinical significance can be made. When comparing the raw data of the respondents, it is clear, in some measured areas of the study, play therapists' clients

showed greater improvement. For example, nine respondents in the play therapists' group and 10 respondents in the non-play therapists' group reported clinical or borderline scores on the Internalizing Scale. All nine play therapists' clients showed a reduction in symptomology, whereas only six non-play therapists' clients reported an improvement. Concerning the Externalizing Scale, all five play therapists' clients who reported clinical or borderline scores reported improvement, while only five of eight non-play therapists' clients who reported clinical or borderline scores improved. On the Anxiety/Depression Sub-Scale, each group had six clients report in the clinical or borderline range. The play therapists' clients had a mean difference improved score of 12.7, while the non-play therapists' clients only improved by a score of 6.2; less than half. Why is this important? Because, individually, the play therapists' clients did somewhat better in particular areas of concerned issues and symptomology, reporting less problematic symptoms. The play therapists made a difference with some of the individual clients. However, results of this study did not rule out the possibility that these improvements may have been the result of chance.

Why was statistical significance not found? There may be a number of reasons. One reason may be due to the small sample size. Had the sample size been larger, say 100-200 respondents per group, a statistically significant difference might have resulted. The play therapists had improved scores on all scales, and a larger N might have influenced the overall mean scores. The limitation of number of subjects should be taken into consideration when interpreting these findings.

Another reason could be this study focused only on clients' self-reported symptomology, taken from a self-report assessment. Client honesty is of the utmost

importance when reporting results from any self-assessment, and individuals, for one reason or another, might not be comfortable with that medium. A recommendation for future studies would be to give clients a survey and/or a verbal interview, as opposed to using only archival data, gleaned information from an alternate source to determine differences in the therapeutic experience. It would also be interesting to administer a survey or interview to the counselors, determining to what degree they used their specialized child-centered play therapy skills with their adult clients, or blind judges evaluating counselors' use of relationship building skills. In future research, video taped sessions of clients to determine if symptomology in session matches the reported symptomology on the assessments would be informative. Also, video-taping the counselors and observing what degree child-centered skills are being utilized is recommended.

Another recommendation is a longitudinal research project to determine if counselors who are educated in child-centered play therapy will become stronger in their relationship building, non-verbal skills, and use these skills with adult clients. Also recommended, tracking the non-educated play therapists to see how and if their counseling styles change.

Another possible reason statistical significance was not discovered in this study could be due to play therapists from this particular program do not perform statistically significantly better with adult clients than the non-play therapists from this program. As stated earlier, all Master's students in this counseling program are highly encouraged and graded, first and foremost, to establish a solid working relationship with their clients, displaying a certain degree of basic counseling skills with their clients before employing

more theory-specific interventions. The non-play therapists from this study, at this level of therapeutic education and prowess, might not take a significantly different approach to counseling than play therapists. It would be interesting to compare adult treatment outcomes between Master's practicum child-centered play therapists versus Master's practicum counselors/therapists from a completely different program, say a psychology program. Future researchers might be interested to compare two groups of counselors who were much further along in their counseling experience, education, and abilities, for example, doctoral students or counselors in the community.

From a research perspective, there appeared to be no previous studies or documented information determining if additional skills, education, and training in child-centered play therapy at the Master's practicum level of counseling education would translate into better adult treatment outcomes than Master's practicum level counselors who are not educated in play therapy. All Master's students involved in this study had undergone classes that seriously emphasized the importance of establishing and maintaining a therapeutic relationship. It could be beginning counseling students, regardless of play therapy training or not, will stay within the relationship building phase during their practicum experience, understanding their evaluation depends on this particular skill.

This research highlights an area of a particular counseling approach, child-centered play therapy, and therapeutic outcomes that are correlated with that approach and knowledge. An investigation was performed to determine if counselors who are educated in child-centered play therapy, when presumably applying these specialized skills and methods with their adult clients, would out-perform their non-play therapy

counterparts. In this study, child-centered play therapists did not statistically significantly outperform their non-play therapy counterparts.

Limitations of Study

A limitation of this study may be the level of therapeutic talent each Master's student possessed. Although great lengths were taken to ensure all participants had an equal amount of classes and clinical training/experience, some participants most assuredly have better counseling skills than others. Also, research is limited to using only archival data for this study.

Another limitation is the amount of distress or symptoms the adult clients possessed. Although clients in this study were not assessed for presenting issues or varying degrees of subjective distress, these factors may have varied among clients in a way that influenced results. Only one instrument was utilized, the Adult Self-Report, which is a self-assessment; therefore, client honesty and accuracy was necessary for accurate results and was assumed but not affirmed objectivity. Further limitations include outside variables that impact outcome measures of therapy, such as client expectations, community clients versus student clients, age, gender, and the supervision skill of the practicum professors and doctoral students responsible for educating the counselors throughout practicum.

In this study, I examined only self-reported behavioral change, assuming that client outcome resulted from the strength of the counselors' therapeutic relationship skills and child-centered play therapy methods. No other methods of data collections were used.

The possibility of master's students identifying and utilizing different guiding counseling theories is a possible factor in outcome. However, it is important to understand that in this particular counseling program, the faculty greatly emphasizes spending extensive session time establishing and maintaining a therapeutic relationship with all clients. Specific theoretical counseling techniques could be performed, typically in latter sessions if at all; yet, first and foremost, practicum students are mostly required and encouraged to develop and hone relationship building abilities. It is also important to remember, as mentioned in earlier segments of this study, that research strongly suggests various psychotherapies and counseling approaches do not differ significantly in client outcome effectiveness. It is possible the play therapists did not necessarily use their specialized child-centered counseling skills with adult clients.

Clients received only 10 sessions each, and concerning client distress, extra therapeutic factors, and levels of individual symptomology, 10 sessions may not have been enough to determine significant change. Also, the strength of the therapeutic relationship was not measured in this study. This research strongly emphasized the relationship as a critical variable in client treatment outcome. It was not determined in this study whether play therapists actually built better relationships with their clients.

College student respondents may not have responded as honestly as community clients. There is a possibility the college students measured in this study were concerned that professors or other students they knew would be viewing their sessions or reviewing their assessments.

Respondents, on the day the pre or post-assessment was completed, may have been feeling either uncharacteristically high or low and, consequently, may have not

answer questions in an accurate manner that truly reflected their symptomology. Another concern is education or reading levels of the respondents, in that some questions asked on the assessment may have been confusing to some and not others.

APPENDIX A

INTRODUCTION TO PLAY THERAPY SYLLABUS

Counseling Program

University of North Texas

COUN 5700 Introduction to Play Therapy

Course Syllabus

I. Goals of the course: Each student will develop an integrated understanding of children's developmental communication and will acquire the necessary play therapy skills needed to facilitate children's expression, self-understanding, personal growth, and development. Observation of and supervised experiences in play therapy are integral parts of the course.

II. Learning Objectives: The student will be able to

A. Demonstrate an understanding of children's perceptual view of their world. (CACREP II.K.2.a,b,c,d; II.K.3.b,c; II.K.5.b,c,d)

B. Explain how children communicate and the rationale for using play therapy. (CACREP II.K.2.a,b,c,d; II.K.3.b,c; II.K.5.b,c,d)

C. Identify the meaning, implications and themes of children's play behavior. (CACREP II.K.3.b,c; II.K.5.b,c,d)

D. Identify the toys and materials recommended for play therapy and explain their purpose.

(CACREP II.5.b,c,d)

E. Demonstrate the ability to establish a safe relationship with children which is empathic, understanding and accepting. (CACREP II.K.5.b,c,d)

F. Demonstrate the ability to empathically respond to the content and emotional expression in children's verbal, nonverbal and play behaviors. CACREP II.K.5.b,c,d)

G. Explain the rationale for therapeutic limit setting, identify areas where limits are needed and demonstrate the ability to effectively implement the steps in setting limits. (CACREP II.K.5.b,c,d)

H. Demonstrate the ability to facilitate a helping relationship with a child in at least four play therapy sessions. (CACREP III.G.I)

I. Explain how to determine therapeutic progress in play therapy and the steps in preparing a child for termination. (CACREP II.K.5.b,c,d)

J. Explain how to utilize parents in the therapeutic process. CACREP II.K.5.e)

K. Demonstrate an understanding of three of the major theoretical models of play therapy.

(CACREP II.K.5.c,d)

L. Identify and use relevant American Counseling Association ethical principles, legal considerations in working with children and appropriate multicultural considerations in the playroom. (CACREP II.K.2.b,c,d; II.K.5.g)

M. Demonstrate the ability to write topical research papers.

N. Effectively assess oneself regarding personal and skill areas of strength and areas for growth. (CACREP II.K.5.a,b,d,e)

III. Methods of Instruction: Involvement and learning in the course will be facilitated by

discussion, role-playing, lectures, small group experiences, films, videotapes, demonstrations, reading in the field, exploratory papers, observation of play therapy sessions and supervised play therapy sessions

IV. Required Texts and/or Readings:

Axline, V. (1983). Play therapy. NY: Ballentine.

Axline, V. (1985). Dibs: In search of Self. NY: Ballentine.

Landreth, G. (1991). Play therapy: The art of the relationship. Muncie, IN: Accelerated Development.

See attached EDSS 5700 Bibliography

V. Student Performance Evaluation:

A. Critique of observation of play therapy sessions - 5%

B. Four clinical play therapy sessions - 30%

C. Topic research paper - 20%

D. Theory research paper - 20%

E. Exam - 25%

APPENDIX B

PRACTICUM IN COUNSELING COURSE SYLLABUS

Counseling Program

University of North Texas

COUN 5700 Introduction to Play Therapy

Course Syllabus

I. Goals of the course: Each student will develop an integrated understanding of children's developmental communication and will acquire the necessary play therapy skills needed to facilitate children's expression, self-understanding, personal growth, and development. Observation of and supervised experiences in play therapy are integral parts of the course.

II. Learning Objectives: The student will be able to

A. Demonstrate an understanding of children's perceptual view of their world. (CACREP II.K.2.a,b,c,d; II.K.3.b,c; II.K.5.b,c,d)

B. Explain how children communicate and the rationale for using play therapy. (CACREP II.K.2.a,b,c,d; II.K.3.b,c; II.K.5.b,c,d)

C. Identify the meaning, implications and themes of children's play behavior. (CACREP II.K.3.b,c; II.K.5.b,c,d)

D. Identify the toys and materials recommended for play therapy and explain their purpose.

(CACREP II.5.b,c,d)

E. Demonstrate the ability to establish a safe relationship with children which is empathic, understanding and accepting. (CACREP II.K.5.b,c,d)

F. Demonstrate the ability to empathically respond to the content and emotional expression in children's verbal, nonverbal and play behaviors. CACREP II.K.5.b,c,d)

G. Explain the rationale for therapeutic limit setting, identify areas where limits are needed and demonstrate the ability to effectively implement the steps in setting limits. (CACREP II.K.5.b,c,d)

H. Demonstrate the ability to facilitate a helping relationship with a child in at least four play therapy sessions. (CACREP III.G.I)

I. Explain how to determine therapeutic progress in play therapy and the steps in preparing a child for termination. (CACREP II.K.5.b,c,d)

J. Explain how to utilize parents in the therapeutic process. CACREP II.K.5.e)

K. Demonstrate an understanding of three of the major theoretical models of play therapy.

(CACREP II.K.5.c,d)

L. Identify and use relevant American Counseling Association ethical principles, legal considerations in working with children and appropriate multicultural considerations in the playroom. (CACREP II.K.2.b,c,d; II.K.5.g)

M. Demonstrate the ability to write topical research papers.

N. Effectively assess oneself regarding personal and skill areas of strength and areas for growth. (CACREP II.K.5.a,b,d,e)

III. Methods of Instruction: Involvement and learning in the course will be facilitated by

discussion, role-playing, lectures, small group experiences, films, videotapes, demonstrations, reading in the field, exploratory papers, observation of play therapy sessions and supervised play therapy sessions

IV. Required Texts and/or Readings:

Axline, V. (1983). Play therapy. NY: Ballentine.

Axline, V. (1985). Dibs: In search of Self. NY: Ballentine.

Landreth, G. (1991). Play therapy: The art of the relationship. Muncie, IN: Accelerated Development.

See attached EDSS 5700 Bibliography

V. Student Performance Evaluation:

A. Critique of observation of play therapy sessions - 5%

B. Four clinical play therapy sessions - 30%

C. Topic research paper - 20%

D. Theory research paper - 20%

E. Exam - 25%

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